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ABSTRACT

This report contains the proceedings of the first National Conference for School Nurses. The 68 school nurses who participated in the conference represented 38 States, U.S. Territories, and Canada. The following papers are included: "Purposes and Plan of the Conference," "Overview of School Nursing Today," "The School Nurse in Mental Health," "The Epidemiological Approach to School Nursing," "The Delaware School Health Study," "Urban Education--An Administrative Problem," "School Nurse Assistants," "Criteria for Staffing Patterns," "New Dimensions in Curriculum," "New Trends in the Health Curriculum" "The Nurse's Role in Health Education," "New Dimensions in Nursing and Nursing Education," "Leadership in a Period of Change," and "Summary and Challenge to the Conferees." (MF)

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New Dimensions in School Nursing Leadership

PROCEEDINGS OF THE CONFERENCE ON
NEW DIMENSIONS IN SCHOOL NURSING LEADERSHIP
SPONSORED BY THE NATIONAL COUNCIL FOR SCHOOL NURSES
SCHOOL HEALTH DIVISION OF THE AAHPER
AUGUST 3-5, 1968
NEA CENTER, WASHINGTON, D.C.

American Association for Health,
Physical Education, and Recreation
A Department of the National Education Association
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Preface

It is with great satisfaction that we make available these proceedings of the first national conference ever held for school nurses. Professional development of the school health team is a longtime goal of the American Association for Health, Physical Education, and Recreation, and we are grateful to leaders in our National Council for School Nurses and the School Health Division for advancing that goal through this historic conference.

When the council was established less than two years ago, its advisory board set leadership development as a priority and the conference as a way of meeting present needs. It is our hope now that the report will help carry the idea further, serving as an aid to inservice education in local school systems and for state and regional meetings.

The 68 school nurses who participated in the conference are among the outstanding leaders of the local and state groups. They represent 38 states, the Canal Zone, the District of Columbia, the Virgin Islands, and Canada. Many are already involved in planning conferences in their areas, and all have agreed to be on call for such help as may be needed. For reference, their names appear in the roster on page 82.

For those who are adding school nurses to their staff or seeking to improve school health programs, we offer this report as a service of the National Council for School Nurses. Readers are invited to become acquainted with the council's full program and with the association's other efforts in school health.

George F. Anderson
Associate Executive Secretary, Program
AAHPER

Acknowledgments

These proceedings are presented in the same sequence as they were delivered at the conference. The greetings brought to the conference by the association officers and staff, as well as by other NEA units, have regrettably been omitted from these proceedings. However, the conference committee wishes to express its sincere appreciation to all who participated or assisted in this conference and in the production of these proceedings.

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Basco, Dolores. Nurse consultant in community health since 1960, Division of Nursing, Bureau of Health Manpower, National Institutes of Health, Department of Health, Education, and Welfare; B. A., University of Minnesota; graduate of Diploma Hospital Program in Peoria, Illinois; M. P. H. from Johns Hopkins School of Health; formerly school nurse with the Chicago Board of Education.

Bryan, Doris S., R. N. Supervisor of nursing services, Oakland, California, public schools; R. N., B. S., M. P. H., and Ph. D. degrees, University of California; National Council for School Nurses Monograph Committee; first Schering School Nurse Award Selection Committee; president-elect of the American School Health Association; past president of the California School Health Association.

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Goodman, Charles H. Professor and associate dean, School of Government and Public Administration, American University, Washington, D. C.; B. S., Harvard University; M. S., Ph. D., Pennsylvania State University; professor of psychology, personnel, and management, American University (1956-61); assistant dean, industrial psychology, personnel, and management (1961-64); 18 publications in psychological journals; James McKeen Cattell Award in psychology (1944).

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Lambertsen, Eleanor C., R. N., Ed. D. Professor of nursing education on the Helen Hartley Foundation; director, Division of Health Services, Sciences, and Education; director, Institute of Research and Service in Nursing Education, Teachers College, Columbia University; B. S., M. A., Ed. D., Teachers College, Columbia University; USDHEW secretary's Advisory Committee on Hospital Effectiveness; National Commission for the Study of Nursing Education, Inc.; Committee on Education in the Allied Health Professions and Services of the Council on Medical Education of the American Medical Association; National Advisory Council on Nurse Training of the United States Public Health Service.

Nations, Jimmy E. Program director, Central Atlantic Regional Educational Laboratory, Washington, D. C.; A. B., M. Ed., Emory University; completing his doctorate at UCLA; master teacher, Harvard-Newton Master of Arts in Teaching program; research educationist -- Ford Program on the Training of Teachers (1962-64); demonstration teacher, University Elementary School (UCLA) (1964-1966); staff associate, Institute for Development of Educational Activities (1966-67).

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Stobo, Elizabeth C. Conference director; professor of nursing education, Teachers College, Columbia University; graduate of the Columbia Presbyterian Hospital School of Nursing; B. S., M. A., and Ed. D. degrees, Teachers College, Columbia University; M. P. H. degree, Harvard School of Public Health; author, "Today's Preparation for the Nurse in the School," Teachers College Record, Dec. 1955; prepared Metropolitan School Study Council pamphlet "29 Tested Practices in School Health Services;" contributor and consultant to the National Education Association and American Medical Association publications School Health Services and Suggested School Health Policies; completed a study and report on educational preparation of the nurse for school health work (1961) and a second report on school nurse preparation (1966), following a three-day conference of national leaders in nursing education, school nursing, and public health nursing services.

Tipple, Dorothy. First chairman of the advisory board of the National Council for School Nurses of AAHPER; ex-officio member of the Conference Planning Committee; past president, American School Health Association; supervisor of school nursing, New York State Education Department, Albany, New York (1954-present); R. N., Bellevue Hospital; B. A., Hartwick College, Oneonta, New York; M. P. H., University of Michigan.

Tuck, Miriam L. Vice-president for health and chairman of School Health Division of AAHPER; professor, health education; chairman, Division of Health Education, University of Oregon; R. N., Cumberland Hospital, Brooklyn, New York; P. H. N., California; B. S. in public health, New York University; M. A. in health education, Teachers College, Columbia University; Ed. D. in health education, Teachers College, Columbia University; public health nurse; school nurse-teacher -- elementary, junior high, senior high, university.

Vincent, Edith H. Member of Conference Planning Committee; state supervisor of school nurses, state of Delaware, Department of Public Instruction; B. S., M. A., Peabody College for Teachers, Nashville, Tennessee; R. N., Union Memorial Hospital, Baltimore, Maryland; school nurse (20 years), Delaware, Maryland.

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Willgoose, Carl E. Member of leadership conference planning committee; professor of health education, Boston University; author of numerous books and publications; received his doctorate at Syracuse University.

Woodruff, Margaret B. Program coordinator, Division on Community Health Nursing Practice of the American Nurses Association; received her baccalaureate and masters degrees from the University of Pennsylvania.

Purposes and Plan of the Conference

Elizabeth C. Stobo

Approximately one year ago the plan for this conference began to be formulated. The endeavor grew out of a recognition of the need for strong leadership within the school nursing group. At present, one must admit that while there are many capable school nurses actively promoting programs for children and youth, the expenditures of energy are diversified and diminished because of lack of cohesiveness. A conference such as the one we are about to begin could easily represent an early step, by the present group, to stimulate and bring about a concentrated effort for the promotion and unification necessary to deal with many common concerns in the field.

As you know, you came here with a central responsibility. Your presence indicates an interest in meeting that responsibility by going back to your own areas to have similar conferences. Because you come as representatives of different parts of the United States, the ideas you take back, if demonstrated by dots on a map with streamers attached, would stretch from Washington, D. C., to the north, south, somewhat east, and very much to the west.

The plan for the conference is outlined in your program, and the topics each day are designed to cover a central theme. Some necessary shifts in the program may have altered this slightly, but on the whole they remain as planned. Today, the program emphasis is on School Nursing: The Current Scene; tomorrow, on The School Today. Our final session on Monday is a reflection of the theme for the entire conference, Implications for School Nursing Leadership.

You will have noted that there is time provided for small group meetings. At the time of these meetings, each group will select a leader and recorder. You will have an opportunity to share views on the content of the presentations and to draw implications for school nursing leadership. Details for the small group sessions will come later. However, there is one change on your program which you may wish to note now. This afternoon there will be a small group discussion from 4:30 to 5:00 P. M. Dolores Basco's presentation will immediately follow the preceding talk on The Epidemiological Approach to School Nursing. Both of these talks will take about an hour -- approximately half an hour each with time for questions.

On Monday we shall have half an hour for sharing ideas for next steps. We shall try to have this be a stimulating and thought-provoking session rather than a series of dry reports.

No conference is complete without meals, coffee breaks, and time for some socializing. Socializing has been provided for; tonight is available as a night on the town.

Your final assignment before you leave will be to complete an evaluation form. There are only six questions to which you will be asked to reply. As all curriculum developers know, one evaluates in terms of objectives. Three of the questions therefore relate to the objectives originally set up for the conference. They were to hold a leadership conference (1) to stimulate the conferees to hold similar conferences at regional, state, or local levels; (2) to provide an opportunity for school nurses to share ideas and promulgate current information about health, education, and nursing; and (3) to update knowledge of recent research and offer implications for the improvement of school nursing.

The first question on the evaluation form is asked in order to learn whether or not your expectations of the conference were met. One of the questions on the evaluation form is asked to get your ideas of the value of regional, state, and local conferences. There is room for "Other Comments." There you will have an opportunity to express your opinions on topics and matters related to the conference. I might add that brand-new and bright ideas will be welcome!

Regardless of the printed word and verbal communications, each one comes to a conference such as this with his (in this instance her) own expectations. These expectations reflect a variety of past experiences, plus specific emotional feelings at the moment towards one's job, one's coworkers, the world at large, and even oneself. Regardless of this, I hope that each of you has come with a great deal of interest and enthusiasm. I believe you have or you wouldn't be here in the middle of August, which for many represents summer vacation. We want and need your interest and enthusiasm because with this "mind set" we can have some thoughtful, even challenging, discussions. We may disagree but we shall not lose sight of our objective of better leadership for better school nursing service for children in America.

The challenges in school health work are expanding. Children are going to school at a younger age and they are staying in school longer. Children with numerous handicaps and disabilities are being exposed to learning experiences undreamed of years ago. From the triad of teacher, nurse, and physician concerned with the child we have grown to the pupil personnel team on which more than half a dozen specialized personnel are represented. Even in the elementary grades there is not just one teacher but a variety of specially prepared teachers who in many instances have very current and sound knowledge of specific medical problems. I speak for example of teachers for children who need special help under the classifications of the brain damaged, emotionally disturbed, or mentally retarded. This has brought about a need for an adjustment in school programs and environments to accommodate the effects of the larger number of specialists who aid in the care of an increasing number of children with a variety of deviations from the so called "normal." Many program adaptations and changes are necessary. Changes tend to make each of us uneasy, uncomfortable, and insecure until we can find the niche where we can make our own particular contribution. We may need to remind ourselves that from this uneasiness comes progress! With security derived from the identification of our potential contributions and satisfactions earned from our accomplishments, we can be free to assume the leadership which can help us and others in our field to further define and refine our objectives and our everchanging services. The challenge of the conference is to help us become alert and sensitive to what is new, to be inspired to evaluate new ideas, and then to have the courage to implement them for the betterment of school nursing services to children of our land.

John Mason Brown said: "Life owes us little; we owe it everything. The only true happiness comes from squandering ourselves for a purpose."[1]

We are here for a purpose. If it means squandering ourselves, then I believe we are ready.

---

[1] Fadiman, Clifton, and Van Doren, Charles (eds.). The American Treasury. New York: Harper and Brothers, 1955, p. 903.

Overview of School Nursing Today

Dorothy C. Tipple

An elderly gentleman at a prayer meeting testified in this fashion: "I'm not what I ought to be and I'm not what I'm going to be. But anyway, I'm not what I was." I think this statement is a fairly accurate assessment of school nurses today. Obviously, there is much to be done, and your presence at this conference indicates that the willingness to change exists. But we do have the comfort of a solid foundation of accomplishment upon which to build.

The topic implies that I am focusing my efforts primarily on current school nursing practice. While this is true to some extent, I shall attempt to give it a directional approach, for by tomorrow the issues and problems of today will be history. We can afford to linger over the status quo only if it helps us to face the future more effectively. To "tell it like it is," we have to see it like it is, looking beyond the daily tasks to the forces shaping our tomorrows.

For this overview I have selected some of the apparently significant developments which are affecting, and should continue to make an impact upon, school health programs. Several of these developments will be presented in greater depth at later sessions of this conference. The overview is precisely that. It will have achieved its purpose if it challenges us to think through together some of the exciting possibilities confronting us in school health work.

Planning and Organization of School Health Programs

A number of recent trends or activities are affecting the way in which our programs are planned and organized. Changes in education are an example. Some of these changes have been graphically described by a school principal, Beatrice C. Boyles, in an article entitled "As I See It," which appeared in a recent issue of The National Elementary Principal. Miss Boyles states: "Conflict and change are dominant characteristics of our society and its schools. The conflicts and the changes are interconnected and they are endless." From the author's "endless" list I have selected a few that are pertinent for us:

> "Once the educational system was a ladder to the American dream. Then the educational system became a stairway by means of upgrading and a jungle gym by means of proliferation of courses.
>
> Once relations had to do with kith and kin of all ages. Today relations have to do with race.
>
> Once people were afraid of hellfire, damnation, and God the Father, and father and mother and teacher. God the Father seems not to have kept His earlier status; neither has the earthly father, mother, nor the teacher. At least the teacher is in good company in this status loss -- although the loss of fear is a good change.
>
> Once pollution had to do with germs -- not with chemicals in the air, filth in the water, and radios everywhere.
>
> Once communication had to do with telegrams and telephones and books. Now it has to do with feelings. Today words are more outspoken than spoken, and in the uproar we must hear what is not said.
>
> Once sex was optional. Now it may well take the place that math and science took after Sputnik. Possibly sex has more relevance to the problems of people, and our 'basic skills' are about to have a basic shift. When the hardware takes over the job of teaching the 3 R's, maybe teachers can manage better the important job of teaching 3 C's -- Compassion, Civility, and Citizenship.
>
> Computers are coming but they are no more going to replace teachers than milking machines replaced cows. The teacher's milk is that of human kindness. The teacher is needed because some things do not change:
>
> > Man must have his daily bread and elbow room
> > Man must belong somewhere and be accepted by some others near him
> > Man must care for someone and someone must care for him
> > Man must have dignity to satisfy what used to be called his soul
> > Man must have an outlet for that force inside him that demands that he create."[1]

---

[1] Boyles, Beatrice C. "As I See It." The National Elementary Principal 47:6, 1968.

The emergence of the middle school and the nongraded school, the development of preschool programs, the advent of programmed instruction, the impact of new learning theories in curriculum development -- these are among the dramatic changes in education which are of significance in school health.

Among the more recent developments which are already affecting the role of the school nurse are those spearheaded by federal legislation. Douglass Cater points out that "over the past three and one half years, the President has proposed and Congress has passed over 40 major measures for federal aid to education and health. In the past three and one half years, the President has recommended and Congress has allocated more funds for education and health than in the previous history of American government. Today, more manpower -- and more brain power -- than ever before have been mobilized for the effort in these two vital areas of activity."[2]

Some of the recent laws are particularly pertinent to our conference deliberations. One of them is Public Law 89-749, known as the "Partnership for Health" law. Since this bill was passed in November 1966, we have gotten under way with the tremendous task of organizing the multiplicity of health agencies so that comprehensive, continuing, family-centered health care can be provided to everyone. The goal of this activity is well stated in Education and Manpower for Community Health by Hilary Fry in collaboration with William P. Shepherd and Ray H. Elling: "What is needed is the kind of coordination which will keep different groups from tripping over one another in providing health services in one area of health need, while other areas go untended; the kind of vision which can see the total health problem of a community; the kind of knowledge which can establish criteria and evaluate programs according to these criteria; the leadership necessary to get the necessary services into the areas of need; the kind of persuasion that will convince special interest groups of the overriding importance of total health problems and the courage to meet such groups in contest if they put private interest above community interests."[3]

The law establishes a state planning agency and a state health planning council to advise that planning agency. Much of the categorical approach that has previously characterized the administration of federal health funds has been converted to block grants to the states to permit the latter to plan more effectively to meet health needs of their citizens.

---

[2] Cater, Douglass. "Comprehensive Health Planning: I. Creative Federalism." American Journal of Public Health 58:1023, 1968.

[3] Fry, Hilary; Shepherd, William P.; and Elling, Ray H. Education and Manpower for Community Health. Pittsburgh: University of Pittsburgh Press, 1967, p. 57.

The state planning agency, according to the provisions of PL 89-749, may be any of a number of different components of the state government, a representative interdepartmental agency, or a technical or service unit of the executive branch. The law is more specific about the state health planning council. It must include representatives of state and local agencies, nongovernmental organizations, and consumers of health services.

School health personnel should definitely be involved in community health planning as representatives of a very important segment of the community. More effective coordination of community health services should facilitate the activities of the school nurse as she works with children, their parents, and school personnel.

Federal legislation is concerned not only with planning for health services and facilities, but with another critical problem as well -- that of health manpower. We in school nursing have been forced to play the numbers game along with those in the other health professions. We face the dual problem of availability and utilization of personnel. It has been stated that: "It is a waste of scores of health personnel if any perform tasks below the level for which they are trained, when others are available to do the work, and dangerous for any to perform tasks beyond their respective spheres of competence."[4]

There is a definite movement to utilize ancillary help in the school health program. You will hear more about research and experience in this area. I am bringing it to your attention now as an important element in planning and organization of the program. Employment of nonprofessional assistants necessitates

1. A distinction between the professional and nonprofessional tasks of the school nurse

2. Development of a job description for the nonprofessional personnel

3. Careful selection and training of personnel

4. Supervision by professional staff

5. Continuing evaluation of the effectiveness of such assistance.

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[4] National Commission on Community Health Services. Health Is a Community Affair. Cambridge, Mass.: Harvard University Press, 1966, p. 83.

Mention should also be made of the now familiar Elementary and Secondary Education Act which has made it possible to employ school health personnel in greater numbers and to provide related health and educational services for large numbers of disadvantaged children. Title VI of this Act has extended financial assistance to state agencies for the education of handicapped children.

There is one additional piece of legislation which I should mention -- the Child Health Act of 1967. Many of you will recall that the 1965 amendments to the Social Security Act established a five-year program of project grants to take care of all the health needs of children, both medical and dental, in the geographic areas served by the projects. Fifty-four of these projects are now in operation. The Child Health Act of 1967 extends this program in the following ways:

1. It increases the authorization for child health under Title V of the Social Security Act as follows:

   $250 million in fiscal 1969
   $275 million in fiscal 1970
   $300 million in fiscal 1971
   $325 million in fiscal 1972
   $350 million in fiscal 1973
   and for each year thereafter.

2. It specifically calls for services for reducing infant mortality and otherwise promoting the health of mothers and children.

3. For the first time it spells out family planning services as a regular part of health services to our nation. Of the amounts appropriated for child health each year, six percent shall be available for family planning.

4. It continues the program of maternity and infant care project grants and of comprehensive grants for the health of preschool and school-age children until June 30, 1972, after which they become a special part of each state health services plan.

5. It authorizes support of up to 75 percent of the cost of projects to provide comprehensive dental health services for children from low-income families. These projects will study ways of organizing community dental health programs, including ways to increase the efficiency of dentists by using assistants and auxiliary personnel.

6. It combines the maternal and child health program and crippled children's services into one program and requires that the states

assume responsibility for project grants in 1972. It requires the states to make more vigorous efforts to screen and treat children with disabling conditions through intensified casefinding and periodic screenings of children in schools.

7. It specifies that 10 percent of the authorization for child health programs for each year shall be allocated for research and training. Special emphasis will be given to projects which can increase the effectiveness of health care programs by making maximum use of health personnel with varying levels of training. In 1969 this will be $25 million; in 1970 this will be $27.5 million; in 1971 this will be $30 million; in 1972 this will be $32.5 million; and in 1973 this will be $35 million.

It may be that I have devoted too much time to the influence of legislation upon our health programs for children and youth, but we cannot afford to minimize the real and potential effect of this movement on the part of the federal government.

There is another discernible trend which is related to the administration of the school health program within the framework of education. I refer to the movement to bring under one administrative head in each school system all of the so-called pupil services or pupil personnel services. It was early identified that school health personnel, particularly the school nurse, could function most effectively in a team approach. One of the first teams was a medical one, composed of the school physician, other medical and dental specialists, the school nurse, and dental hygienist. Then health in the schools became allied with physical education, and we noted that health and physical education personnel frequently became an administrative unit. This administrative pattern is currently followed by many school districts. In the past few years, however, as more of the supportive services have been added in school districts, there has been a movement to coordinate these services through an administrator assigned to this specific task.

The scope of pupil personnel programs varies from one school system to another. In general, the program includes services in the areas of attendance, guidance, health, psychology, and social work. Some programs include speech and hearing services. School health personnel frequently include the physician, the nurse, the dental hygienist, and occasionally, other health specialists. The school nurse is almost invariably the constant who is an essential member of the pupil personnel team. All pupil personnel workers have a common goal -- to facilitate the full development of each pupil.

The pupil services movement has had an interesting development on the national level. In 1961, under the leadership of the U. S. Office of Education and the National Institute of Mental Health, the Interprofessional

Research Commission on Pupil Personnel Services (IRCOPPS) came into being. The commission is made up of representatives of 19 professional associations brought together originally to see what might be done to stimulate research and demonstration in the pupil services area. A year later, the NIMH funded a five-year research program to be administered by the commission. This program, now being concluded, has been conducted at four university centers: University of Michigan, University of Maryland, University of Texas, and Chico State College in California. Final reports of these projects will soon be available. In the meantime, the central staff of the commission has had its own research projects and has become increasingly involved in consultation with local school systems and state departments of education. One of the major research activities of the central staff and the commission has been a study of excellence in present programs of pupil services. Staff and commission members composed interdisciplinary teams to visit 20 carefully selected school districts throughout the country. The major report on this study should be out within a few months. The first published report growing out of the study is entitled Pupil Services Department -- Functions, Organization, Staffing and is intended primarily for school administrators. It is published by the Administrative Leadership Service and is available from its editorial service, 1041 Fillmore Street, Arlington, Virginia 22201 ($4).

In our increasingly complex school organization, the pupil services approach appears realistic from an administrative standpoint. School health personnel should not, however, be restricted or limited in their activities to the pupil personnel team. They must be free to align themselves with many other teams within the school and in the community. No administrative pattern should be permitted to inhibit this essential flexibility of operation.

The Emerging Role of the School Nurse

School nursing can no more remain static than can any other aspect of nursing practice or of education. It must reflect changing needs in health, in education, and in society itself.

Early in the century much of the school nurse's time was spent on efforts to control communicable disease. Today the many effective preventive measures constitute a springboard for activities to promote positive health. That is not to say that children and youth no longer have health problems. We are a long way from meeting adequately the health needs of the nation's children and youth.

Furthermore, we have major concerns regarding the so-called sociological health problems -- smoking, excessive use of alcohol, drug abuse, and venereal disease. The need for family life education has been clearly identified and is receiving a great deal of public attention.

The major differences which can be identified in the role of the school nurse in the past two decades are related to approach or method. The school nurse is giving priority to activities to assist in the development of all boys and girls -- socially, emotionally, mentally, and physically -- and we seem, finally, to be recognizing the indivisibility of all aspects of health. We are talking about an epidemiological approach, which simply means a scientific study of health status for the purpose of identifying the factors which influence the occurrence of health problems. We have developed an orderly approach to individual health problems through assessment, intervention, and evaluation. We are recognizing that the ultimate solution to health promotion lies with the educative process and, as a result, both community and school health education are receiving priority.

The school nurse is ceasing to be a provider of isolated services. She is becoming an evaluator, a health counselor, an interpreter, a consultant, and an educator. Perhaps this transition can be illustrated by a comparison of two lists of duties of school nurses, one developed in 1938 and one in 1968. These are brief statements which accompany certification requirements for school nurse-teachers in New York State. The 1938 requirements are as follows:

> Subject to the direction and supervision of the superintendent of schools, to assist the school medical supervisor and other school officials in protecting the health of school children; teach health habits and health information through contacts with individual pupils, parents, and teachers; assist in health examinations of school children; visit homes in order to confer with parents regarding the health habits of children; secure the treatment of defects and investigate the illness-absences of children; give instruction in home nursing, child care, and first aid; inspect the school plant and report on its sanitary condition; assist in maintaining first-aid service; cooperate with the public health agencies in the development of family health and the control of communicable diseases; cooperate with the welfare agencies in the health supervision of families under their supervision and obtain treatment of defects of school children; advise teachers, principals, and the superintendent of schools with regard to all matters affecting the health of school children and to do related work as required.[5]

The 1968 statement follows:

> Subject to the direction and supervision of the superintendent of schools, the school nurse-teacher works with other school health and pupil personnel workers in a program designed to promote, protect, and

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[5] The University of the State of New York. Certificates for School Service. Albany, N. Y.: The State Educational Department, 1938 reprint.

maintain the health of all pupils. The school nurse-teacher has a major role in planning, with representatives of the school staff and appropriate community agencies, for a health service program to carry out the school's responsibility in meeting the health needs of pupils. The nurse-teacher serves as a health consultant to administrators, teachers, and other staff members in regard to all matters affecting health of pupils and school personnel.

Representative school nurse-teacher responsibilities include:

1. Assisting in conduct of periodic examination and screening procedures to determine health status of pupils, with such procedures planned to constitute an integral part of the curriculum in health education

2. Counseling with pupils and parents to interpret health problems, to assist parents in utilization of professional resources for diagnosis and treatment, to interpret professional recommendations

3. Conferring with teachers and other school personnel to share and interpret pupil health problems and to develop plans for modifications of the school program

4. Assisting teachers in planning, coordinating, and evaluating health education activities; serving as a consultant in health instruction; assisting in evaluation of health instruction materials

5. Assisting in planning and maintaining a safe and healthful school environment, including the establishment and implementation of emergency care procedures

6. Conferring with representatives of community agencies in matters pertaining to family and community health

7. Providing inservice health education for teachers and other school staff

8. Evaluating outcomes of school health service program.[6]

The emerging role of the school nurse brings her ever closer to the educational market place, to such an extent that we are frequently asked to define what is "unique" about nursing in the school, as differentiated from the role of other school personnel. Perhaps her uniqueness lies in four attributes not held by other members of the school staff:

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[6] The University of the State of New York. Unpublished statement of school nurse-teacher responsibilities. Albany, N. Y.: The State Educational Department, 1968.

1. A commitment to the practice of health as a quality of living
2. The ability to apply nursing skills in dealing with individual health problems
3. The strength of the combined utilization of counseling, consultation, and teaching skills
4. The broad community health approach working through the medium of the educational institution.

Professional Considerations in School Nursing

We cannot complete an overview of school nursing today without some consideration of our progress in attaining professional maturity. School nursing, like any other profession, is in fact a profession to the degree that its members are professional. I am borrowing a statement from TEPS (National Commission on Teacher Education and Professional Standards) to suggest several premises:

A person who qualifies as a professional in any field:

1. Is a liberally educated person
2. Possesses a body of specialized skills and knowledges essential to the performance of his job
3. Makes rational judgments and acts accordingly; accepts responsibility for the consequences of his judgments and actions
4. Believes in his service to society
5. Assumes responsibility with his colleagues in developing and enforcing standards and abides by these standards in his own practice
6. Seeks new knowledge and skill in order to improve his practice.[7]

You will note that three of these six characteristics relate to education. We are moving quite rapidly and surely in nursing education toward the achievement of professional preparation. Our progress in school nursing is less clear. School nurses may have the greatest amount of education of any group within the nursing profession, but they also show the greatest diversity in educational preparation, which is significant. But perhaps even more significant is the fact that the diversity represents a wide range of nursing education. Some school nurses are graduates of associate degree and diploma programs with no additional preparation. At the other end, and the larger end, we have graduates of some of our finest baccalaureate and masters degree programs. In between we have registered professional nurses with conglomerate preparation in health and education. Some states have no certification requirements for school nurses. Others require a year of study beyond the baccalaureate degree.

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[7] A Position Paper on Teacher Education and Professional Standards. Washington, D. C.: TEPS, National Education Association, 1953, p. 2.

Based on these facts we can and should anticipate that the practice of school nursing will reflect the same range and diversity as the professional preparation of the practitioners. As we move in the direction of improved academic preparation of school nurses and more intensive programs of continuing education, we can anticipate a higher level of professional practice.

The fifth characteristic listed in the TEPS position paper was "assumes responsibility with his colleagues in developing and enforcing standards and abides by these standards in his own practice." Implied in this concept is the need for professional organization. It follows then that we must relate the professional person to the organization or organizations of practitioners with which she should be affiliated. Among our responsibilities is the effort to strengthen and coordinate the activities of all professional associations related to school health.

Challenge to the Leaders in School Nursing

In relation to the Child Health Act of 1967, President Lyndon B. Johnson stated: "The work most needed to advance the nation's health will not be done for us by miracles. We must undertake that work ourselves through practical, prudent, and patient programs -- to put more firmly in place the foundation for the healthiest, happiest, and most hopeful society in the history of man." School nurses can and must play an essential role in determining the direction and scope of nursing and related health services to be given.

You are the leaders in school nursing. With you rests the responsibility of defining priorities, making commitments, and initiating and directing action. We can continue with the present kaleidoscopic approach, or we can control the building of a program so that it is a mosaic. Whatever we do depends upon two things: what we think people are like and can become, and our beliefs about the importance of school nursing to help them achieve their capabilities.

The School Nurse in Mental Health

Dorothy Shoobs

A study designed to explore the nurse's functions in promoting mental health of the elementary school child, to project her potential role, and to identify curriculum implications was carried out at Teachers College, Columbia University. This paper was developed from the report of that study. After a preliminary period during which the literature was reviewed, a pilot project was conducted, and instruments were formulated and revised; then the actual study was made. [1]

In the initial phase of the study, a nurse prepared in school nursing (Dr. Elizabeth Stobo) served as project director, and a nurse prepared in psychiatric nursing (this reporter) served as principal investigator. Twenty-three visits were made to four nurses serving six schools in four school systems to observe the kinds of problems which arise in the course of the school nurse's day, and some of the opportunities she has to deal with these problems. Visits were planned to sample the differing events that occur during a school year. To do this, visits were made near the beginning and middle of a semester, before and after a holiday, at a non-holiday time, and in fall, winter, and spring.

Permission to observe in each school was obtained from the superintendent of schools and the nurse coordinator of the school system. The individual nurse to be visited was contacted before visits were made in order to familiarize her with the purpose of the study and to plan the days and hours for the visits.

At the beginning of the visits, each nurse showed the observer where she might sit in order to be in a position to see and hear what transpired without disrupting the usual activities in the health office. Wherever possible, the observer recorded during the observation. When this was not possible, notes were made immediately after the observation. Since more information was obtained than was provided for by the instruments, the observer made anecdotal notes on the additional information, then read these into a tape recorder after each visit.

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[1] This study was supported by Grant 1 TI MH-9475 from the National Institutes of Health, United States Public Health Service.

The tape-recorded notes and data from the instruments were then transcribed. At this time two part-time project assistants were added to the study. One was prepared in psychiatric nursing and the other in pediatric-psychiatric nursing. Each of the four investigators analyzed the data; then they met to resolve any differences. No real differences were revealed.

The study data showed that the nurse promoted mental health in the school in a variety of ways. She provided emotional support for the child by working directly with him and by working with others on his behalf. She provided emotional support directly to the child by:

1. Reinforcing positive behavior
2. Educating for anticipated stressful events
3. Reducing feelings of tension and anxiety
4. Building self-esteem
5. Developing insight and understanding of behavior
6. Enhancing coping skills
7. Establishing limits.

Indirect provision of emotional support to the child was accomplished by:

1. Providing emotional support to adults such as teachers and parents
2. Modifying policies or procedures
3. Adjusting the physical environment
4. Facilitating communications.

After a variety of attempts to categorize the observations, the categories of "vulnerable moments" and "vulnerable situations" were developed by the project director.

"A vulnerable moment denotes a given point in time when an event occurs and the nurse or others may anticipate that stress will result. This may be thought of as the acute phase or the point at which an illness may begin."[2]

"A vulnerable situation denotes a circumstance that is less transitory than a vulnerable moment and one in which the nurse can reasonably expect stress to exist."[3]

Vulnerable moments include such events as entering school, transferring to another school, having a substitute teacher, having emotional tensions within the environment, participating in school screening procedures, school fire and civil defense drills, approaching menarche, facing short-term health problems, and going to the hospital.

Vulnerable situations include facing long-term health problems, dealing with physical disability and illness, having illness in the family, having a death in the family, dealing with problems in the life situation, and attending public school during psychiatric treatment.

Vulnerable Moments

The vulnerable moments and vulnerable situations are illustrated with examples from the observations, then analyzed and discussed.

It is suggested that school nurses can prevent or minimize emotional stress and its adverse effects upon children by becoming acutely aware of those situations that are inherently stressful to children. Freeing the child from excessive stress can aid him in developing his personality in positive directions and free him to learn in a creative manner.

The study takes a close look at many of the aspects of areas mentioned under "vulnerable moments" and "vulnerable situations." I will discuss several of these.

A vulnerable moment -- entering school.

At the beginning of a child's school life, school personnel have the opportunity to create a good emotional climate. The study raises the question of consideration by the school staff of the child's expectation of his first experience in school. These expectations are gleaned from what he has heard from adults, siblings, and playmates; then they are translated according to his personality and experience. He may approach school with feelings ranging from glee to fear and may end the first day eagerly anticipating the next, or disillusioned because he was in school for an entire day and did not learn how to read. A variety of parental expectations and attitudes are considered and suggestions are made regarding the first school contact. The purposes of preschool registration are reviewed, and questions are raised about the pertinence of some of the practices which are now in effect.

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[2] Stobo, Elizabeth, and others. The Nurse in the Elementary School: Promotion of Mental Health. New York: Teachers College, Columbia University, 1968, p. 17.

[3] Ibid., pp. 17-18.

Some of the questions which need to be explored are: As a consultant in health, what can the nurse do to make the initial school contact a pleasant and rewarding learning experience? Is privacy provided for mother and child during the interview? Does the nurse have an opportunity for observing the mother and child interaction, but also a chance to see the mother alone where she can speak without being distracted? It is suggested that supervised play might be planned for the child, or perhaps he might visit the kindergarten. Is consideration given to the feelings of mothers during this period of separation? Could an orientation program be held to help them deal with these feelings, thus indirectly helping the child during this difficult time of separation? During this orientation period, the parents may be helped to understand the developmental needs of the 5-to-6-year-old child. Later tense situations may be relieved if the parent knows, for example, that regressive behavior may occur.

With what attitudes do the parent and child leave the school after their first meeting? Do they leave with a feeling of warmth and dignity? Do they feel that the school is interested in them? Or do they leave happy to be away from the commotion, feeling that the school is merely collecting information it needs, and, since school attendance is required by law, that they must fulfill this obligation?

In considering the activities concerned with the entrance of the child into the school it might be good to review periodically the amount, kind, and use of data collected. Other considerations are: Does the classroom teacher receive a composite summary of the data in time for it to be useful to her? Is information clarified when necessary? Is it shared with discretion for the benefit of the child?

The nurse has the responsibility to keep the administration informed of practices that, in her view, are ineffective or detrimental, as well as having the responsibility for creativity in improving practices.

A vulnerable moment-- school screening procedures. Vulnerable moments may occur during school screening procedures. For example, a vulnerable moment could take place during appraisal of vision and hearing. If the child has not experienced these procedures, they may be frightening to him. Preparing for stress in advance of the stressful situation may alleviate tension, so anxiety associated with screening procedures can be reduced by having the child learn about the activity prior to its occurence.

Fear of the unknown is lessened when that which was unknown becomes familiar.

Reduction of fear is not accomplished only for ethical reasons. Since perceptions are diminished in the face of anxiety, it is possible that hearing and visual acuity will be lessened when the child is very frightened.

Practices used to acquaint children with the purpose and methods of the various health-related activities may include classroom or small group discussions and demonstrations before the activities are carried out. It is common practice to involve the child when planning for various screenings. In one school system the observer accompanied the school nurse to an orientation session for kindergarten children who were to undergo audiometer screening.

- The nurse showed the earphones to the children and asked, "Who wears them?"
- The children answered, "Astronaut." "Pilot." "The man in the police station."
- The nurse then had one child try on the earphones. She asked the children to be quiet so he could hear the message she was sending him. The children giggled.
- She had the child repeat what he heard. He mimicked the sound. The nurse turned up the volume so that all of the children could hear the sound.
- Next, she asked the teacher to select a child, and she instructed the child selected to don the earphones and tap with a ruler when he heard the sound. She selected three children to come to the health office with her, and told the class that when each child finished, he would return to class and choose the next child to be screened. The next child would then come to the nurse's office.
- As each child came up to be screened, the nurse asked him what he would like to be (astronaut, pilot, policeman, etc.). She repeated her instructions to tap with the ruler when the child received her message (heard a sound). The children generally wore expressions of pleased anticipation as they participated in the screening.

Handling the screening procedure in this manner made it less threatening to the children. By showing them the screening apparatus and demonstrating its use, the nurse acquainted them with it. Thus they were not afraid when they came to the health office for auditory screening. By having the children participate in the task, she gave them some control over what was happening. This, too, diminished their anxiety.

In another school system, the teacher and psychologist were interested in the results of vision screening on Archie because he seemed to be in a daze at times. Since the child was in kindergarten, there was no past record of his vision screening.

- When the nurse attempted to screen Archie, an anxious child, she determined that he had a short attention span because he would give one or two correct responses, then begin to give erroneous responses. Therefore, the nurse changed the subject briefly each time this happened, then resumed screening. At this time, she received correct responses each time.
- When she finished, the nurse asked Archie how he felt. He replied, "It's O. K. I was a little scared because I thought it would touch my eye."

During the screening the nurse was able to observe the child's behavior, make a nursing diagnosis (short attention span), and then modify her approach in order to obtain more valid findings. The child was given the opportunity to express his anxiety when he was asked how he felt after the event. Had a less skilled person been doing this screening, recognition of the child's short attention span might have been missed and the subsequent follow-up could have led to anxiety for the child plus expense for his parents. The adjustment in his curriculum made necessary by his problem would also have been different, and a delay in adopting satisfactory methods to deal with his class work could have resulted.

Archie and his family benefited from the close working relationship that existed between the teacher, the psychologist, and the nurse. This child's health record was negative for any pathological findings, but the expressed interest of the teacher and the psychologist over his classroom behavior alerted the nurse to possible inconsistencies in the results of his visual screening. These shared observations brought satisfactions for the school staff whose consequent cooperation promoted and simplified referral procedures and prevented wasted efforts and confusion. This incident illustrates the informal referral procedure which frequently takes place within a school. It also points out the importance of routinely including the nurse in the formal procedure of referring a child to various pupil personnel workers. The routing of any referral to the nurse gives her an opportunity to add what she knows about the child's health and behavior, thus providing the consultant with increased background knowledge before he sees the child.[4]

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[4] Ibid., pp. 32-34.

Vulnerable Situations

Since the school nurse's greatest efforts should be exerted on behalf of health promotion and the prevention of ill health, it is hoped that she would become more involved in vulnerable moments than in vulnerable situations. However, where vulnerable situations do occur, such as in instances where children already show evidence of maladaptive behavior, there is a need to build upon the strengths within that situation. It is important for the nurse to realize that a vulnerable moment may be superimposed upon a vulnerable situation, thus making it even more difficult for the child to cope. The more competent the school nurse and others are at selecting and dealing with vulnerable moments in the lives of children, the greater the likelihood that eventually there will be a reduction in vulnerable situations.

A vulnerable situation -- dealing with problems in the life situation.

Every school system has some children from families who have grave social and emotional problems of the type known to community health and welfare workers. The school nurse usually encounters these children when the family problems have an adverse effect on the children's health and behavior. The following case report illustrates how disturbances in family living may influence the child's behavior in school, and the way in which the nurse as an accepting adult figure can serve as a stable and continuous source of emotional support and guidance for the child in such a situation.

- Austin and his sister transferred to this school from another school when he was in the third grade. (At the time of the observations he was in the sixth grade.) The children had had a good relation with the school nurse-teacher in their other school, so as soon as they came to this school, they came in to meet this nurse. Austin usually comes to the nurse daily, although at times he may skip as much as a week between visits.
- Austin's parents were divorced and each had remarried. His father has custody of Austin and his older sister. Relations with the stepmother were very good until she began to have babies of her own. She now has four young children, including a set of twins.
- 10:00 A. M. Austin came to the nurse's office from mathematics class. He said, "I don't feel so good. I feel uneasy, shaky." He rested for a few minutes and returned to class; then promptly came back to the nurse.
- After this second visit, the nurse called the teacher to ask what happened. The teacher said, "Nothing."
- While the boy is doing poorly in all school subjects, the nurse noted that he made frequent visits to her during his mathematics class. Investigation revealed that the mathematics

teacher cannot see Austin's point of view.

- The nurse interviewed the child. She asked if he had a problem with his teacher, and he said no. She suggested that he return to class, but he sat outside of the door and kept wandering into the office and back out again. He returned to class reluctantly.
- 10:28 A. M. Austin again returned with another somatic complaint. After a brief assessment of the physical symptoms, the nurse interviewed the child. He told her that he was going to spend the weekend with "my first mother and she is pregnant." The nurse listened quietly to his story. When he finished she sent him home for lunch, telling him to remain at home if he felt ill. He refused.
- 1:00 P. M. Austin stuck his head in the office and said, "Hi!" and left.
- 1:30 P. M. The nurse conferred with the school psychologist, who knew the child. The nurse reviewed the child's behavior and after the discussion asked the psychologist if he could see the child again. He agreed to do so.
- After a holiday recess, Austin came to see the nurse. He seemed to be rather depressed. He did not have a good time with his mother and considered the holiday a failure.
- The student had become a frequent visitor to the nurse's office. He generally initiated these visits through a somatic complaint, but occasionally he dropped in merely to say hello, to talk with her, or to show her something.
- The nurse conferred with Austin about his visits to her. She told him that she would be pleased to see him before or after school or at lunchtime, but that he was coming in too frequently during class hours. Austin accepted the suggestion very well and kept to this schedule. The nurse made a point of welcoming him on these visits.

It is apparent from the number and nature of the contacts Austin initiated with the nurse that he viewed her as a source of help when he was distressed. The nurse or any other adult figure in the school who has a good relationship with a child is in an excellent position to give support to the child during a stressful period. The nonthreatening image and behavior of the nurse helps to meet the immediate needs of the child and to reduce his excessive anxiety. While she accepts the child's somatic complaints by her assessment of his condition, she does nothing to reinforce this pattern of behavior. The nurse provides emotional support and security by giving comfort, encouragement, approval, and acceptance and by setting realistic limits.[5]

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[5] Ibid., pp. 65-67.

Summary

The observations from this study indicate that as a specially prepared resource person in health, the nurse has knowledges and skills different from those of other staff members. Because of her role, she is able to follow a child and often a family during the school life of that child. She cares for the child during a period when he can be considered to be in a state of vulnerability because of his age and the various influences that constantly impinge upon him. Knowledge of a child's state of vulnerability can assist the nurse to be helpful to him as she provides emotional support in a variety of ways. This knowledge can also be used to plan total health care for children and to establish priorities for nursing services. As school nurses identify and give priority to the vulnerable status of children, they can aid in the development of health programs which focus on primary prevention in the area of mental health, and also minimize untoward effects of stress.

The Epidemiological Approach to School Nursing

Cecil Slome

This morning at breakfast, I asked a nine-year-old child, "What does a school nurse do?" She replied, "Examines my eyes!" I questioned further with, "Sally, what else does she do?" The curt answer came back, "Nothing! And she's a beast!"

In a recent article, a rising senior student in the School of Nursing, Duke University, commenting upon the present status of school nursing, writes, "If a poll were taken of the general population's belief as to what a school nurse's function is, parents and children alike might well reply, 'a band-aid pusher.'"[1*]

Further, in another recent article, a physician questions the quality of school health services, stating, "A casual view will show not only that these services are inadequate, but that the value of the resource (our children) being protected is not fully appreciated."[2]

I would like to start at this point; here are three critical opinions. You may say that it is a matter of communication. I may say it is a question of a number of us refusing to accept dogma, reluctant to accept that what you say you do and your claimed achievements are factually realized. (By "you," I mean school nurses.)

There is the apt saying of the German philosopher, Carl Becker, that "we need from time to time to take a look at the things that go without saying to see if they are still going," which is a healthy admonition to school nurses today.

One reads in journals of school health and in school nursing journals statements such as "School children will be healthy if they will continue to have the services of nurses dedicated not only to help them reach their optimum health, but to help maintain that high level,"[3] implying, perhaps,

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[*] See endnotes, page 32.

that the health problems of school children would be resolved if more school nurses were available to do more of their present activities. In fact, in a study by Poe (quoted by Forbes[4]), school nurses "indicated that if they had more time in the schools they could perform activities with greater frequency" -- just more of the same, it would seem.

I think these viewpoints need questioning, and hope to show you that epidemiology is critical to such inquiry and to your functioning.

A pamphlet of the American Nurses Association[5] lists a total of 83 functions of the school nurse. Permit me to read a few of them.

> "Function 1A (Planning) -- Participates in the formulation of objectives . . . of the school health program.
>
> "Function 2D (Implementing) -- Compiles and uses records, reports, and statistics for appraising and planning the school health program.
>
> "Function 1C (Study and Research) -- Participates in planning and carrying out epidemiological studies." So perhaps I do not need to apologize for being at this conference.

Further functions listed include "determining health needs of the school population," and "investigates the climate of school and community as it affects the health of the school population."

The question is, and I hope to carry you with me to consider the solution, how do you ascertain these needs (and hence priorities)? Do you merely suck the answer out of your thumb? Do you experience a single dramatic experience such as a child falling, and claim that problem as a priority? Or do you use scientific methods in appraising needs?

In 1965, a study in Oregon[4] showed from the ratings of nurses' activities by a randomly selected sample of elementary and high school teachers that the top four ratings were occupied by "conferences with teachers, correction of defects, visual rescreening, and first aid administration." These teachers' ratings did not jibe to any marked extent with the nurses' self-ratings of their own activities.

It seems, therefore, that many functions, important ones, are just not being carried out. I fear that some of these lacks are inherent in the "nature of the beast," really. The attributes were well described[6] in regard to Englishmen, but I fear may well portray many school nurses, too -- "The characteristic virtue . . . is their power of sustained practical activity, and their characteristic vice a reluctance to test the quality of that activity by reference to principles. They are incurious as to theory, take fundamentals for granted, and are more interested in the state of the roads than in their place on the map. And it might fairly be argued that in ordinary times, the combination of intellectual lameness with practical energy is sufficiently serviceable to explain, if not to justify, the equanimity with which its possessors bear the criticism of more mentally adventurous (nations)."

So quite frankly, it seems school nursing is in a mess, which may be one reason why you are all at this conference. It is probable that you are reaching or have already arrived at a stage (and perhaps you should have started in 1894 when school nursing commenced) of sitting back to think, to adventure mentally with reduced practical activity. Thinking is what is needed.

You may well question what epidemiology could offer you in this process. The reply is fairly easy if the basic principles of the science are understood.

If you are concerned only with the diagnosis and care of an individual child, then you do not need epidemiology, for that personalized assessment and practice require clinical skill and judgments, be they of a nurse or physician. But, if one of your functions (and it is included in the aforementioned list) is the assessment of and health programming for a school population -- that is a group -- you can only use epidemiology, for that is what it is all about. So if you wish to carry out this important group diagnosis for scientific health programming, you had better learn epidemiology.

This science will not be able to direct you in the care of individual children; that is the art of nursing. But if you are attempting to identify priorities, and the best health return for your day's work, and what are the correlates of your school health problems, and what outcome, healthwise, you may expect if these processes are reversed, then you will need epidemiology.

If you set out to assess the problems of a school population, epidemiological techniques will readily tell you the most prevalent disorders and identify the groups suffering the highest rates of these problems. This is purely descriptive and will not tell you "why." Nevertheless, this will show you where to apply your services, which groups have high rates; i.e., this will establish scientifically your priority groups for care.

I am concerned about this, for it seems relatively less important for my daughter's eyes to be examined in comparison with the vast number of children in schools in America today who are in greater need and much more disadvantaged than the likes of my child. They need it more than my child, and yet you go on as if all children are at equal risk, which is patently wrong.

Further, this picture will tell you the characteristics of the "high-rate-of-illness" groups. Are they the first graders, or the seventh graders, the Negroes, whites, or Puerto Ricans, or children from broken homes who have high rates of illness? This sort of cross-sectional epidemiological group diagnosis can be carried out in a matter of weeks -- literally (provided adequate data are available).

If you do not carry out this scientific group appraisal, you will be tempted to generalize from your individual clinical cases, and for many reasons may err considerably in these conclusions.

This procedure will also indicate the prevalent disorders of today's school children, for many of your actions and functions may not be geared to the present-day disorders -- you may be out of phase with what is going on today.

Further, if you apply analytic epidemiological methods correctly, you will be able to identify the antecedents -- the causes of these health problems; i.e., the processes or behaviors that precede their onset in factual terms and not in erroneous generalities derived from hunches or beliefs. Therein lies the only hope of identifying those factors in need of change to prevent the onset of illness in school children. You will be able, also, to calculate the amount of reduction in health problems you can expect as a result of your action directed toward the necessary promotion of more healthful preventive behavior.

This procedure requires prospective, longitudinal studies, which are time-consuming but seem a "must" if we are to identify factors which place children at high risk, and thus those antecedents which require change. This is the basis of adequate preventive health action. The emphasis at present is on school nurses attending to ill or disabled individual children, which, helpful as it may be, will do little to prevent the onset of new cases of these disorders. This dictum applies to all human illnesses, including the infectious diseases.

The tragedy is that there are people who still write in otherwise excellent articles that, "Statistics give little insight about the way accidents occur. Case histories tell the clinician more,"[7] illustrating a very limited view of statistics and the contribution of epidemiology to the identification of "causes."

So, using basic methodology, you can fairly rapidly identify the groups of school children with high rates of illness demanding priority of attention, and with that picture and your clinical experience, you can draw hypotheses for testing in prospective studies. If you have ideas or hunches about the causes of the problems, by all means state them and let us venture to test them. But they are merely hypotheses, and should not be assumed to be fact until they have withstood critical testing.

I am also concerned, deeply so, that not enough attention is being given in school programs to the prevention of pathogenic behaviors of adulthood. Children, unfortunately, slip very rapidly into adulthood, and I do not see evidence that habits of adulthood which are detrimental to or promotive of health are receiving the necessary attention during the school years. That is when it all starts and ends, quite frankly, and we recognize too well the difficulty experienced in changing the adult behaviors which were ingrained in childhood.

We know, for example, that children of parents who smoke are more likely to become smokers themselves than are children of nonsmoking parents. I say to you, should this not be identified as the child enters school, and should some indication not be made to such parents of the likelihood of their own children smoking and suffering the health consequences as adults? In a similar vein, one can consider action against dental caries, the most prevalent disorder of school children. There are known behavioral correlates of caries and these need discussion with the parents. Health behaviors are not randomly distributed, and children generally learn them from their parents, which suggests your attention be directed to parents and their behavior. It raises the tantalizing indication, in fact, that your routine health examination should be of parents and not children.

Further, you need to keep a continuing group diagnostic picture in the forefront, an ongoing epidemiologic surveillance, for this will keep you abreast of the natural history of the problems you face, and confront you early with the changing patterns of diseases, and their correlates. This is most important, for with the vast social, environmental and other changes occurring in this country, it is imperative that you keep abreast of their health consequences.

Since mandatory school integration, many changes have occurred in schools and in the programs for school children; we all are aware of them, and they may well have profound health implications. Do you know what they are? Are you attempting to become aware of changing disease and health behavior patterns resultant from these major societal reorderings, or are you still fussing about diphtheria and small pox? If you systematize a stream of relevant information with modern data processing techniques, you will have answers overnight -- if you ask questions!!

Thus, in terms of ongoing diagnoses of your groups of school children, not of individuals but of groups, epidemiology will guide you to priorities, and can help you identify antecedents or risk factors, and hence point up your necessary preventive actions. This science would not tell you how to carry out this practice. If I ventured to pass such opinion, it would be as a physician and public health practitioner rather than as an epidemiologist.

Another matter of concern is brought to mind by the sort of opinions one reads and hears that a rough but useful measure of the thoroughness of the physical examination is the number of pupils examined per hour. This system's approach to quality is distressing, as generally in public health, and particularly in public health nursing, we are way behind in the evaluation of our activities. Tawney describes the characteristics that permit this to go on, bringing to mind all too readily many nurses. "The blinkers worn enable them to trot all the more steadily along the beaten road, without being disturbed by curiosity as to their destination." His advice should be heeded by all, for "it is necessary to know where (the road) leads, and if it leads nowhere, to follow another. The search for another involves reflection, which is uncongenial to the bustling people who describe themselves as practical, because they take things as they are and leave them as they are. But the practical thing for a traveler who is uncertain of his path is not to proceed with the utmost rapidity in the wrong direction: it is to consider how to find the right one."[6]

Epidemiological principles have a great contribution to make in this necessary evaluation of your services. Unfortunately, perusing the recent guidelines for school nursing,[8] it seems that in the self-evaluation alone are included approximately 120 questions, almost all of which are behavioral, such as "Have I allowed time for conferences?" "Have I cooperated with all agencies?" and "During home conferences have I stressed accident prevention?" I say, who cares? I say to you, does it matter to the health of the school population? Whatever you do, if you stay at home and drink coffee and by so doing you are reducing the rates of new cases of disorders in your school, your program is successful. If you leave no time for conferences, and if by what you are doing or enabling, you can reduce rates of illness, that is success. It may not be because of your actions, but nevertheless the health of your group is improving, which is our aim. On the other hand if you answer affirmatively to all 120 questions, and the rates of emotional disorders and accidents are rising, you are unsuccessful, even if you have had a thousand conferences.

It is not easy to find evidence that this nature of evaluation is high in your priority of activities, that is, evaluation in terms of health and not how busy you are. Parenthetically, let me encourage you to experiment in your delivery of services, for you are in a wonderful position to carry out health services research -- provided, as ever, you measure the outcome in health terms.

Let us examine a few of the major health problems of today's school population in terms of what I have said.

Studies carried out in 1961[9] indicated, and I am sure you all know this better than I do, that "emotional problems have become the most serious and difficult problems of children of school age." Showing prevalence are rates of 19% of 1st-to 11th-grade children considered to be "maladjusted," with 8% of 9th graders considered to have "serious adjustment problems." Many references suggest that about 10% of school children have serious emotional problems. Further, the data indicated that in New York City, "about 20% of school children are in need of child guidance services, and that many could be identified, if not prior to school, on the first routine health appraisal on admission to school."

And I asked myself, "Why must my child's eyes be examined and not her emotions?"

Among school children, emotional problems are perhaps only second in importance and prevalence to dental caries. Starting from there, one would want to know what characterized this 20%. Illness is not randomly distributed in humans, and small groups contribute disproportionately larger amounts of illness. These groups can be identified. In so doing, and with your vast experience in dealing with school children, you should be able to suggest the nature of these children and possibly hypothesize as to "why?" You then proceed to test these hypotheses. There is an element in considering emotional problems that should concern you more than it does, and that is the teacher. I do believe she (he) is generally omitted as a variable implicated in the production of emotional disturbances. This opinion is not new, for even 30 years ago a study showed[10] "the personality of the teacher is the most important and pervasive element influencing the mental health of the children." Further, in a study at that time (and nothing suggests there has been an improvement) "about one-third of a group of typical classroom teachers studied were reported as lacking in proper emotional adjustment." I do not wish to state that teachers alone cause emotional problems, but I do believe we should question their involvement in the process. Maybe our proposed examinations of parents should be applied also to teachers, and include an assessment of their emotional status. It is disheartening for me to learn that the California State Department of Education abandoned compulsory physical examinations of applicants for teachers' certifications without substituting at least an emotional assessment of these future teachers.

So if you ask pertinent questions, developed from concepts of practice, and you apply epidemiological techniques, you will get answers.

It is not necessary to mention to you the prevalence rates of accidents, for you must carry a big load of the outcomes of these incidents. We know something about the epidemiology of accidents, but are we doing anything with what we know, and are we choosing from this body of epidemiological information that which should be implemented in rational action?

For example, a study in Vancouver[11] indicates that most accidents involving child pedestrians occurred on clear days, in daylight, during June and September, mainly on school days from 3-6 P. M., primarily on residential roadways. Further, it seems[12] that we know some characteristics of those children who are likely to be involved in accidents, as Keddy[13] and others indicate "it is abundantly evident that the accident-prone child is no myth." They are the children of parents who are distant in their relationships to the children, and who have a casual attitude to injuries. Wheatley adds that "child-rearing practices and parent-child relations may well be found to be the nuclei of accident-producing behavior, not only in childhood but also in adulthood."

Surely, then, you school nurses should try to obtain an early assessment of those key ingredients, the parents' concern about accidents and their relationship with the children. If this information is correct, then these children at high risk can be identified and afforded high priority of attention, which, it is hoped, will reduce their accident rates.

The outcome, therefore, in evaluatory terms, must be health, the reduction of disease or disability -- not how many conferences you've had. That is an intermediary, for if you have the optimal number of conferences and the rates of disease rise, then clearly the conceptual basis linking conferences with health outcome is at fault, and a new road needs to be sought. If you do achieve your aim healthwise, it is still conceivable that this success was due to another activity, even possibly that of someone else. This is the scientific approach to programming and demands constant questioning and application of principles.

My own view is that somehow, sometime (and preferably soon), if you want people to understand what school nursing is all about, and if you want to be clear and to be shown your achievements objectively (and that is most important for all of us), you must record your aims in specific health terms -- the reduction of this rate of disease, or that rate of disability -- and set about measuring the degree of achievement.

I realize it is easy for this to be said, but it isn't difficult to do. Keep it simple (for it is easy to be complicated) and you will receive simple answers. What I am stressing are a number of principles concerned with the health of a group, principles which are basic if you want to function scientifically in regard to the school children's health. If you do not, then keep going along your way, unthinkingly, with your blinders on. This was well put nearly 2,000 years ago by Marcus Aurelius when he wrote, "If you will return to your principles and the worship of reason, within 10 days you will seem a god to those to whom you are now a beast and an ape."

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The Delaware School Health Study

Dolores Basco

This is a long range study which was begun about a year ago and will require about five years to complete. The purpose of the study is to identify the characteristics of groups in the school population at high risk for absence and illness and then to design and test new patterns of nursing service for these high risk groups. This investigation is being carried out in three phases. We have just completed collecting the data for the first phase.

The literature was carefully reviewed and discussions were held with representatives of the Delaware State Departments of Public Instruction and Public Health to determine the important factors to consider in selecting the study population. A random stratified sample of 2,080 pupils representing urban-rural, racial, broad age range, and socioeconomic differences was chosen. These pupils were enrolled in forty-three public and parochial schools throughout the state. Data were abstracted from their 1966-67 school health, attendance, and cumulative records. Additional data were collected from 1967-68 attendance records. Preliminary analysis of the data suggests pupils have more episodes of absence when they come from lower socioeconomic groups, from broken homes, or from large urban areas; when they are one year or more overage for grade; or when they have low grade-point averages. Tenth graders were found to have the highest number of absences; first graders ranked second and were followed by fourth graders. Seventh graders had the lowest.

In the next phase, visits to homes of a selected sample of the study population will be made to collect information about family social and health characteristics. Based on data obtained from school records and home visits, hypotheses will be developed regarding high risk groups. The final phase of the investigation will be a controlled experimental study in which new modes of school nursing services for high risk groups will be developed and tested.

This study illustrates one way in which epidemiology can be used to strengthen school nursing practice. We can use epidemiology in many ways to help us build a scientific base for school nursing practice. This will enable us to change our practice intelligently so that we can make the maximum contribution to the present and future health of school populations.

Urban Education—
An Administrative Problem

Leroy C. Dillard

I want to talk with you briefly this morning about the major problem which confronts us in education -- the development of a sound educational program which will meet the needs of urban children.

You as school nurses know, as I do, how our educational system has failed the urban child: His academic achievement is low; the percentage of students going to college is small; the dropout rate is high; there is difficulty in the teaching of reading; and high school graduates are poorly prepared for jobs.

No matter in what major city you live, you know that these problems exist, and you know, too, that when we talk about the education of the urban child, we are talking about the education of the minority group child -- primarily the Negro.

About a year ago, Judge J. Skelly Wright handed down a decision which affected the Washington school system. His chief finding was that we in the public schools in Washington had, over the years, been discriminating against both the poor and the Negro.

He used as evidence these facts:

1) Our per capita expenditure was higher in the more affluent areas than in the poorer areas of our city.

2) Our more capable teachers were assigned to the more affluent areas of the city while our less experienced teachers were assigned to the inner-city areas.

3) Our inner-city schools were far more overcrowded than were the schools in other areas of the city.

4) School buildings and school facilities in the inner-city area were much more rundown and dilapidated than schools in other areas.

5) We assigned Negro teachers to predominantly Negro schools and assigned white teachers to schools that were predominantly white.

If all this is typical of the major cities across our country, then it can be said generally that we in education have been discriminating against the poor and the Negro -- and that our major problem is this:

> How do we provide *equal* educational opportunities for all of the children who are served by our public schools?

In an attempt to solve this problem, our cities have been developing special programs, generally with federal funds.

So we hear of programs for the disadvantaged, programs for the deprived, programs for inner-city children, programs for ghetto children, programs for hard-core families.

We operate Headstart programs, work-training programs, tutoring programs, enrichment programs -- and with all these programs our successes are minor, and we sometimes wonder if we are not wasting the funds that we have received.

We have studied the inner-city Negro child and his family *ad infinitum.* Without these studies we already know generally that he is poor; that his parents have poor jobs or cannot find employment; that frequently he is hungry; that he lives under poor housing conditions; and that his neighborhood is rundown and poorly maintained by the city.

These are things that we can see *without* studies. But with studies we learn *additional* facts: He is poorly motivated; he is restless and aggressive and needs more psychological help than other children need; his family is loosely organized; his parents don't display an interest in him; his attention span is short; he can't communicate with us; he can't think in abstract terms; and he doesn't speak standard English, so he needs English as a second language.

These things which we have learned from studies focus our attention on how different he is. Isn't this stereotyped thinking? Doesn't such thinking make the development of sound educational programs more difficult? This, then, is another problem which must be overcome:

> The eradication of stereotypes in connection with the poor *and* the Negro.

The problem of urban education has become even more complicated in recent years. That segment of the city which had always been quiet and submissive is now demanding to be heard.

Inner-city citizens want to have a part in whatever decisions are made. They want to help choose sites for buildings, help select the architects who design the schools, participate in the development of curriculum materials, and choose the teaching and administrative personnel.

New voices are being heard, and at times these voices are strong and militant.

At one of our recent board meetings, students in one of our high schools demanded that they be allowed to participate in all decisions that affected student personnel in their building. This included participation in determining how they should be dressed, what should be served in the cafeteria, and whether or not they should be allowed to leave school during the day when they had free periods.

They also demanded that they be permitted to set up a freedom school where they could choose their own teachers who would teach them of the contributions that Negroes had made to American culture.

Adults in the inner city are increasing their demands that the schools in their communities be put under local control. They want to develop local boards of education, make the school personnel responsible to them; and they, the local community, want the right to determine what should be taught and how it should be taught.

The demand is for new materials, for the inclusion of Afro-American history in the curriculum, for African art and African music.

The demand is for teachers and principals who live in the neighborhood served by the school and for local citizens to work as paid employees in the educational system.

There is also the demand that education be made relevant to the needs of the children served by the schools.

So these new and often militant voices are being heard. The problems that city school systems face are:

1) Who really speaks for the poor and the Negro? and

2) How do we respond to the demands that are being made?

In the past year or so some of our cities have been scenes of civil disturbance. In Washington, in April, following the death of Dr. King, large areas in the city were burned and looted.

Children participated in the looting; children saw adults looting; the homes of some of our children were burned; children were frightened by what they saw; and children were frightened by the presence of soldiers in their schools.

In the wake of these disturbances, how does the school system react? Shall it ignore what has happened? Shall it pass moral judgments? Or shall it use these events to develop relevant educational programs?

Social changes, civil rights campaigns, poor people's campaigns -- all these present new problems for the schools, problems which complicate the effort to develop equal educational opportunities for all children.

Still another problem facing urban educators grows out of the findings of the Coleman report. Among other things, the Coleman report emphasizes the fact that integration of poor Negro students with either middle-class Negro students or middle-class white students brings about the best results in terms of achievement.

If a school system subscribes to this belief, the problem is how to go about achieving this integration. Shall we change our school boundary lines? Shall we bus children? Or shall we develop cooperative urban-suburban programs? If we believe in developing integrated educational programs for city children, we have major problems to overcome, since whites are escaping to suburbia and middle-class Negro children are escaping to private schools.

And now, the final problem that I want to mention is concerned with the excuses we offer for our failure to do a better job for Negro children who live in the inner city.

I've indicated that we're developing stereotypes of children in the inner city -- they can't think in abstract terms, they can't communicate, they don't use English, they have poor concepts. These are our excuses for failure.

Could it be that the ghetto in which our poor and our Negro children live -- this physical, social, and emotional environment steeped in the unhealthy and the unwholesome -- could it be that this is not the worst problem they have to face?

Could the maximum impediment be that unbreakable noose which is forged around them by the minds of others?

Could their futures be circumscribed by the attitudes of adults -- the hopelessness of parents who nurture them and the limited faith, both of the administrators who plan for them and the teachers who teach them?

Do they have to fight against an educational system that believes that less than the best is good enough for them?

Do they have to contend with a system that offers differing courses in different schools?

Must their curiosity be directed in the ways that we think proper?

Are advanced science courses and advanced mathematics courses atypical in their schools?

Is this excused on the grounds that these children do not choose these courses, that what they need is special education and vocational education?

I'm indicating to you that if the big educational problem in America is the development of good programs for the poor and the Negro, the dwellers in the urban ghetto -- the greatest ghetto may be in the minds of those of us who are responsible for their training.

Through all kinds of preservice and inservice programs, we are becoming technically more proficient in the teaching of reading, mathematics, and science. We are becoming skilled in the use of technology. But all of this is useless unless within the hearts and minds of the education profession there is a sincere belief that the children we teach are individuals and are as capable of learning as any other group.

In the Washington Post on May 1, 1968, William Raspberry concluded an article on the middle-class Negro by saying:

> "It may be that the most important contribution of all would be to take the hand of one child who is trapped in the ghetto and help him to see that escape is possible."

I would apply this to teachers, administrators, parents, school nurses, and all those associated with a school system. Skills are necessary and extremely important. We need to know how to teach reading. We need to know how to develop skills in the new math. But if we are going to solve the problems of the urban child, it will be with a change in our own concept of him.

And it may be that the most important thing you can gain here at this leadership conference this summer is the faith and determination to take the hand of one child who is trapped in the ghetto, and help him to see that escape is possible!

School Nurse Assistants

Doris Bryan

The need for better use of the school nurse's unique knowledge and skills is constantly stressed in groups of professional health workers and educators. Recent trends, primarily in federal legislation, have resulted in the schools' making many more demands on school nurses. Many school districts are increasing health services, and others are adding school nursing services where there were none a year ago.

State legislation now requires school nurses in California and in many other states to have education beyond the public health nurse preparation level, so that there are fewer qualified school nurses to fill these positions; then, too, the increasing technical nature of the health field has made great demands on professional time.

In addition to school demands, there is an increased need for public health nurses in generalized public health nursing services. As a result of Medicare, home nursing programs are requiring more staff to meet urgent needs of the public (as are other population groups, including the acute and chronically ill). These programs will utilize not only more public health nurses, but various levels of staff, including registered nurses without public health preparation, licensed vocational nurses, and subprofessional aides, as well.

The implications of this situation are clear-cut. There will be fewer highly trained public health nurses to provide more complex services to greater numbers of people. This means, therefore, that any agency,

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Note: For more complete details, the reader should refer to Bryan, Doris S., and Cook, Thelma S. The School Nurse Assistant: A Report on the Subprofessional Worker in a School Health Program. California School Health Association Monograph Number 4, October 1966, upon which this paper is based.

including the school, must utilize to the greatest degree the public health nurse's abilities and the skills for which she is trained, and must recognize that persons with various levels of training can make effective contributions as members of the school health team.

In order to supplement meaningful health services for the hard-to-reach and lower socioeconomic segments of our society, and with the federal government applying a financial stimulus to provide more training and jobs for lower socioeconomic groups, a force of competent workers must and can emerge. Subprofessionals can, with careful, creative supervision and training, ease the burdens of the professional and perform many neglected and/or new services.

Because it was felt that the school nurse could be the key person in the school to work with students, parents, and community agencies -- acting as a liaison between the school and the home, interpreting school problems to parents and family needs to teachers and principals, and assisting parents in seeking adequate medical care for their children as well as themselves -- the three-year project "Redirection of School Nursing Services in Culturally Deprived Neighborhoods" was begun in September 1965 with the following threefold purpose:

> First, to determine if a planned program of personal contacts with parents by the school nurse would increase parental action toward maintenance and promotion of the health of the school child and the prevention of illness; second, to determine if full-time nonnurse assistants could carry out, under supervision, specific routine functions ordinarily performed by qualified school nurses, thereby leaving the nurse free to devote more time to parent counseling, parent education, and child supervision; and third, to determine if released time for the school nurse would, in fact, be used for the exercise of higher knowledge and skills by the nurse.

The project began with a proposed list of activities. Early determination of the duties of the nurse assistant was essential in order to select the right person for the job. The nurse assistant wanted to know what was expected of her; the school nurse to whom she was assigned needed to know what to expect from her; and school personnel needed to be oriented to this new person in the nurse's office. These activities, all or a portion of which could be performed by the assistant, included maintenance of the nurse's office, participation in health appraisal activities, individual child health supervision, record keeping, responsibility for health education materials, and others. The position of the nurse assistant has been a developing and a changing one; it can therefore be assumed that her activities will change with experience, new knowledge coming forth from the project, and overall program change in the school district.

Three nurse assistants were recruited to participate in the project. Between April 1965 and June 1966, they were provided with an initial 20 hours of formal inservice training and orientation in addition to four weeks of observation and participation in the school setting. Although this training was directed toward the acquisition of specific skills, proficiency was gained in the daily practice of these skills under the supervision of a skilled school nurse.

An evaluation of the three nurse assistants was carried out each year of the study. In all areas, the three were found to be doing a better-than-satisfactory job, and in some areas, they were outstanding. They exercised good judgment in assessing the needs of students as they came to the health office; they understood and were able to carry out accident and emergency policy with desired skill and safety; and they sought help and guidance from the school nurse as needed. There is evidence to indicate that a full-time nurse assistant can indeed carry out the routine functions assigned to her and that she would be a great asset in the total school health program.

In conclusion, I would like to reemphasize the "musts" for effective utilization of the nonprofessional that Dorothy Tipple brought out so well in her keynote address yesterday:

1. There must be a clear distinction between professional and nonprofessional tasks.

2. A job description for the nonprofessional must be developed on the basis of what a person can do, not on what the nurse feels she would like to give up.

3. Careful selection and training of personnel is imperative.

4. Continuous supervision by professional staff, trained to supervise, is necessary.

5. There must be a continuing evaluation of the effectiveness of such assistance.

And finally, my own number 6:

6. Adequate preparation of nursing staff and school personnel for the nonprofessional is essential.

Criteria for Staffing Patterns

Irma B. Fricke

One of the most perplexing and challenging situations facing the professions today is that of staffing. School nursing is no exception. When one views the multitude of changes taking place in our present society, this is not difficult to understand. Greater demands for more service, increased shortages of qualified personnel, newer and more complex kinds of health conditions, changing goals, and rapidly rising costs all tend to complicate the problem. Though the fact of numbers cannot be completely overlooked, traditional staffing patterns of yesterday are in many respects outmoded. Old pupil-nurse ratios have lost their value with present emphasis on needs and what it takes to meet them. Optimum staffing will require a reassessment of present circumstances, establishment of realistic and meaningful goals, a study to determine what is needed to meet these goals, and long-range planning for the future.

Functions of the school nurse have not only changed but have greatly expanded as well. Larger pupil enrollments, bussing of school children, mandatory legislation bringing the handicapped child to school, and newer government programs such as Headstart have all added new dimensions to the school health program.

A look at the ANA publication, Functions and Qualifications for School Nurses, shows twenty major functions with eighty-three subheadings, and this does not include all the activities necessary to implement these functions.[1] A special issue of the Journal of School Health, entitled "The Nurse in the School Health Program: Guidelines for School Nursing," lists six major responsibilities with twenty-two subheadings, plus two additional sections dealing with the school nurse as an educator and the school nurse as a counselor.[2] It would appear that more nurses are needed to serve fewer students. The answer is not so simple. First, additional qualified personnel are not available. This fact alone requires that other avenues or resources be explored.

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[1] American Nurses Association. Functions and Qualifications of School Nurses. New York: the Association, 1966.

Perhaps one of the most difficult obstacles to overcome is the resistance to change, characteristic in varying degrees in each of us. If change is to be effected, involvement of professional personnel is basic. Each must be helped to see, understand, and feel within his own person the necessity for change and sincerely desire with an open mind to try a different way of doing things. This can be a painful process, requiring patience, understanding, encouragement, and support. The oft repeated phrase, "Too much to do with too little time to do it," can be a powerful incentive for stimulating or initiating action. No simple answer is available. We need to examine our programs for possible changes; plan for better utilization of personnel, resources, and facilities now available; and explore other avenues for help.

Too often we may keep on doing the same thing year after year just because it has always been done. Surely we should evaluate the worthwhileness of many of our present activities and determine their value. One of the most common complaints heard in the school today is that something new is always added but nothing is ever taken away. Certainly, in view of the different and complicated health problems now facing children and youth, new priorities need to be established with many former activities abandoned or reassigned to a position of lesser importance. We can no longer expect more nurses to do the same old thing. This means that we must discard activities no longer necessary or those which contribute nothing to the health and education of the child. Furthermore we need to make better use of those resources and facilities now available. These include a reevaluation of nurse responsibility in view of the members of the many newer disciplines, such as social workers, guidance counselors, and psychologists, now working in our schools. Coordination of the nurse's knowledge and skill with that of other professionals not only lessens the burden on the nurse, but many times results in a better solution when she is resolving adverse health situations. Problems reviewed, discussed, and planned through a team approach may relieve the nurse of much frustration and enable her to use to better advantage the knowledge and skills she does have.

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[2] School Nursing Committee of the American School Health Association. "The Nurse in the School Health Program: Guidelines for School Nursing." Journal of School Health. Vol. 37, No. 2a, February 1967.

In addition, the nurse has at her disposal many newer kinds of help, such as the greater varieties and kinds of aid now available through government programs; the use of devices such as computers, programed instruction, and data processing; many new community health and welfare agencies offering special kinds of services; and a whole host of communication facilities. The best use of all these aids in an appropriate manner can do much to save her time and make more effective her activities as she implements a sound school health program.

The efficiency expert is well known to all. Everywhere people and programs are being examined with particular focus currently being turned on education. The nurse as a member of the school team cannot expect to be exempt. Better utilization of personnel, facilities, and resources is essential. The waste of professional talent and skill on nonprofessional tasks is well known to all. The nurse can no longer afford to spend her time at tasks that do not require professional skill and responsibility. It has become necessary to explore other sources for help to perform those tasks requiring a less skilled individual. There remains, then, the question of who is going to carry out those activities which, though not requiring nursing skill, are still a necessary part of the work to be done in the nurse's office. Many professions are looking to a fairly new kind of helper known by many titles, such as aide, assistant, or auxiliary worker. The employment of such persons raises several questions, however, relative to recruitment, selection, training, defining of functions, and supervision.[3] Certainly there may be distinct advantages to the employment of qualified auxiliary workers. Sometimes we might be tempted to settle for anyone just to get relief. This could be tragic. A study carried out in Los Angeles city schools illustrates that having additional help does not necessarily free the nurse to carry out those professional responsibilities and make those professional judgments which only she is qualified to do.[4] On the other hand, another study reported in the Oakland, California, schools demonstrates that with good and careful planning, auxiliary help can be of great value to the nurse.[5]

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[3] National Commission on Teacher Education. Auxiliary School Personnel: A Statement by the National Commission on Teacher Education and Professional Standards. Washington, D. C.: National Education Association, 1967.

[4] Randall, Harriet B.; Cauffman, Joy G.; and Schultz, Carl. "Effectiveness of Health Office Clerks in Facilitating Health Care for Elementary Children." Journal of Public Health 58:897-906, 1968.

[5] Bryan, Doris S., and Cook, Thelma S. "Redirection of School Nursing Services in Culturally Deprived Neighborhoods." Journal of Public Health 57:1164-76, 1967.

Certain facts must be remembered. The auxiliary worker or health aide is just that -- with the nurse always being the manager or supervisor. It is the nurse who must help define the duties for the aide, assume responsibility for her training and supervision, and plan carefully to use her time most effectively. Since the line between professional and nonprofessional tasks is by no means always clear, it will be the responsibility of the nurse to analyze and determine the professional and nonprofessional elements of a function. She will set up a schedule for the aide and develop a plan of evaluation to determine that not only the aide's, but also her own time is being used to the best advantage. Though responsible for continuous supervision, she must guard against its becoming an all-consuming activity preventing her from accomplishing even that which she had previously been doing.

Much of the nurse's work is of a highly confidential nature, and auxiliary personnel must understand that in having and using such information, he or she must be guided by ethical standards. Here, as with others working in similar positions, a breach of professional ethics cannot be tolerated. Certainly if the employment of auxiliary workers is to become a common practice, professional standards must be developed as well as some plan for ensuring high standards of practice.

The auxiliary worker must never serve as a nurse substitute nor be employed in the stead of a nurse. This means that a program of auxiliary help will, contrary to the popular assumption, cost more money. It is essential that the school board, the administrator, and all other school personnel be familiar with the program in order to gain their cooperation and support. The board of education must consider establishing a salary schedule commensurate with the training of the aide and provide job security, the same as it does for other nonprofessional personnel. In addition to basic office training, the auxiliary worker will require preservice and inservice education to acquaint her with those features unique to the nurse's office. This would include familiarity with health records and materials for instructional purposes, as well as procedures for emergency care of accidents and illnesses. A knowledge of school organization and lines of communication will do much to facilitate the success of the program.

Training for the nurse in the use of auxiliary personnel is most important to the success of the program. The nurse must be willing to relinquish some of the things she has been doing. Occasionally there may be a nurse who does not wish help.

In establishing guidelines for the auxiliary worker or health aide, nonprofessional tasks might be considered those not requiring professional skill or judgment. Generally these include those tasks dealing with materials and equipment and requiring more nearly the education of a clerk. Legislation in some states may effect the determination of the duties which the aide may or may not do.

Clerical duties appropriate for an auxiliary worker or health aide include:

1. Answering telephone calls and taking messages during the nurse's absence
2. Filing records, reports, and other data
3. Typing correspondence, reports, and other necessary papers and communications
4. Recording objective facts such as vision, hearing, and immunization information, on cumulative health records
5. Reviewing pupils' records and obtaining health information for nurse's use (information for follow-up or other purposes)
6. Preparing certain reports appropriate and necessary (parent notifications, dental reports, accident reports, and others)
7. Taking inventory and requisitioning supplies
8. Making up and maintaining checklists to compile statistical information for studies, surveys, and projects
9. Requesting transcripts of health records for new entrants and forwarding transcripts of health records of pupils transfering
10. Assisting in initiating health records for new pupils.

Duties the auxiliary worker or aide may assume in giving emergency care (consider also the legal implications) include:

1. Carrying out emergency procedures according to standing orders under the supervision of the school nurse
2. Preparing kits and distributing first-aid material to teachers.

Duties the auxiliary worker or aide may perform when working with instructional materials include:

1. Ordering, organizing, and filing health educational materials
2. Typing, duplicating, and collating instructional materials related to health
3. Taking materials to and from classroom

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4. Arranging health educational materials in waiting room, on bulletin boards, or in other exhibit areas

5. Preparing displays of pictures, models, etc.

Duties the auxiliary worker or aide may assume in assisting the school nurse include:

1. Preparing rooms for testing procedures (where examinations are performed in the school)

2. Setting up and putting away equipment

3. Scheduling and assisting in getting pupils to the health office

4. Pulling and refiling cumulative health folders for use by the school physician and school nurse

5. Making appointments for parent, teacher, or pupil conferences

6. Preparing conference room

7. Escorting young or handicapped pupils to and from the health office (this might be for any purpose requiring that they come to the office)

8. Helping in preparing these children for school health examination

9. Selecting material for specific purposes

10. Escorting children to and from the nurse's office for screening procedures or other activities.

Although auxiliary or nonprofessional workers are being used more extensively, as reported by the Oakland, California, study, it remains to be seen how successful the widespread use of such a plan may be. Certainly, with good pre- and in-service education plus continuous qualified supervision, an auxiliary worker may be of much value to the school nurse. The routine use of the aide to screen pupils who should or should not be seen by the school nurse poses some questions. Not only does the nurse's professional insight place her in the position of making observations which might escape the notice of a lesser-qualified individual but may deprive the nurse of an opportunity to give much-needed counseling. It would be unfortunate if the aide should come between the nurse and the child. The health and interest of the child must be the prime consideration. To be more definitive is difficult. Each nurse must be guided by her own good judgment within her own situation.

Certainly the wise and judicious use of qualified assistance would do much to release the nurse to give more and better service to boys and girls. Reports of projects are available which demonstrate the value of such help as well as the pitfalls to avoid. Though further studies are much in order, there are at present sufficient guidelines to enable the nurse to make good use of such help. What best serves the health interests of boys and girls must be the goal.

New Dimensions in Curriculum

Jimmy E. Nations

The term "curriculum" has a lot of general -- even vague -- meanings attached to it; and, of course, phrases like "new dimensions" give a speaker a lot of leeway. I'm going to try to focus on a particular definition of curriculum, and then I'll talk about some new kinds of things that are happening in curriculum -- some new dimensions that I see in the school's curriculum.

When I speak of curriculum, I mean a purposive occurence in an instructional setting. The central focus of the curriculum is a learner, and the curriculum does not come into being until that learner is interacting in an instructional setting. The curriculum, by this definition, is not a thing that can be written down in a book and handed out. What can be written is a description of what we hope is going to happen. What is written is a curriculum plan, but it is not the curriculum. The curriculum must take place in an instructional setting around a learner.

There are four other elements that have to be included in that instructional setting. One is a learning problem. The learner interacts with this learning problem. He faces the learning problem and has to deal with it. Too often in schools, youngsters don't know what the learning problems are that they are supposed to be dealing with, and, as a result, their curriculum never happens. I think it's important that youngsters know the learning problems with which they are being confronted.

The second element that goes into the making of the curriculum is some kind of expected outcome in terms of behaviors for that learner. The purpose of curriculum is to bring about changes in the behavior of the students. Changes are made in relation to a learning problem, so, in order for the curriculum to occur, there has to be a learner in action dealing with a learning problem -- with some kind of expected changes in his behavior. I use the term behavior to mean ways of thinking, ways of feeling, and ways of acting. It is important to look at behavior as overt actions, thought processes that produce those overt actions, and the feelings or attitudes that go into those thought processes that lead to the ways of acting.

The third element that has to be brought into a situation for the curriculum to occur is learning materials within an educational environment. I don't mean to say that the environment in which the curriculum occurs has to be the school because a museum, a playground, the streets -- all can be educational environments. We should make no mistake about the fact that youngsters are involved in curriculum and that curriculum takes place out in the streets, in the neighborhood, and in the home. The school curriculum is one that takes place under the auspices of the school; but I think if we are going to have effective curriculum in the schools, we absolutely must recognize that a youngster is involved in curriculum in a variety of places. The implications are that we need to know the kind of curricula in which the youngster is involved in all of his other life situations. Thus, the third element of the curriculum is the environment or the situation within which the learning takes place. Within this situation, the learner interacts with the learning problem and develops certain kinds of expectations for changes in his behavior.

The fourth element in the curriculum is the evaluation or the feedback that the youngster gets from having been involved in a learning situation and having dealt with a particular learning problem. The evaluation that I talk about in terms of the curriculum is the evaluation that the youngster uses. So often we talk about evaluation as something that happens aside from the whole learning process. We talk about evaluation as something that we generally test outside of the learning situation. I think the most important kind of evaluation takes place as the curriculum takes shape: where the youngster either knows he has made some changes in his behavior or finds out that he has not made changes in his behavior.

This concept of curriculum can be likened to an amoeba. It is constantly moving and taking new shape. If you prod an amoeba in one place, all of the rest of it is affected. If you give some input to one element of the curriculum, all other elements are affected.

As I have talked about curriculum, I have not included a teacher as an essential element. I have done this purposely because I believe that learning can and does take place without teaching; however, a good teacher is a most important force in helping the curriculum take shape. He is the greatest single factor in facilitating learning.

This represents a departure from traditional ways of thinking about education because most of us usually think that education involves a teacher imparting his knowledge to a group of learners. We give more emphasis to didactic teaching and to studies of teaching than we give to learning. The purpose of schools is not teaching. The purpose of schools is to provide a setting in which learning takes place. All of us who are teachers must recognize that our role is secondary to the role that the learner plays and that what we do is secondary to what the learner does in the school situation.

Within this framework, let's move to some new dimensions in curriculum. There's an old saying that "there is nothing new under the sun." I think that is almost true in school curriculum, but there are some new ways of organizing. We have made some reassessments, and we have made some adaptations. But always, whenever there is a school setting, there have been learners and there have been learning problems and expectations. All of these elements have been in schools as long as we have had schools. But new dimensions can be described in terms of the way these elements are emphasized, the way they are organized, and the adaptations that are being made for them.

Let's look first at learning problems. In the current curriculum reform movement, which was begun in the early 1950's, we have looked at learning problems and we have reorganized the content of learning. We have assessed the areas in which we have been dealing with learning problems. In mathematics, for example, the mathematicians looked at the learning problems that were being presented in the area of mathematics, and they said, "First of all, the schools are not teaching mathematics as a content area; they are teaching arithmetic. They are only teaching skills for computation." They were reassessing the content or the learning problems that were being represented. They said, "Schools should be teaching mathematics. They should be dealing with concepts of set, concepts of number, concepts of numeration, and so on." The computational skills in arithmetic are only secondary to an understanding of mathematics. There was a change in the kind of learning problems that were being presented and being dealt with in mathematics.

As one looks at one national project after another dealing with curriculum development, one of the problems one finds in the projects is reassessing the kinds of content -- or learning problems -- that are being presented to students and with which students are being challenged. We are reorganizing and reassessing the content with which we are dealing.

In the program I am now working with, we are developing curriculum in the arts and humanities. In the visual arts, which is one component of our program, we find that many of the activities presented to youngsters as art experiences are merely direction-following activities. In the majority of the activities presented to youngsters, directions are given and directions are followed. The ability to follow directions is important. But this should not be presented under the guise of teaching the arts because there are concepts, there are ideas, there are perceptions involved in art which should be the basis for developing curriculum in art.

Thus, one of the activities in curriculum development is a reassessment of the content or learning problem based on the particular area in which we are dealing, and the reorganization of that content.

In the past, we have organized learning problems in small boxes, stacked one on top of the other. In first grade, the youngsters had these things to do; in second grade, they had these things; and in third grade, this, and so on. When you look at the kinds of sequences we build with these little boxes, you find that there wasn't much that was logical about the sequences.

A couple of years ago, while I was working at UCLA, we did a study of early childhood schooling in the United States. We traveled to major metropolitan areas and visited schools in adjoining suburban and rural areas. It was amazing in that study to see how frequently we would find the same thing going on from one place to another. Do you know that most schools in this country still teach "Indians" in third grade? Nobody knows the logic for it -- it isn't that the kids are particularly interested -- but teachers feel obligated to teach Indians in third grade.

The point of this example is that we have had a tendency to put content areas in little boxes reserved for first grade, second grade, third grade, and on up. And there is little logical tie-in as we move upward. (I will never forget one experience when I was teaching in Florida. I had a group of six-, seven-, and eight-year-old youngsters. We had learned a new song. We were singing it when the music specialist came, walked past the door, stopped dead in her tracks, and looked in at me. I was pleased. The children were doing very well. They sang nicely. That's why I beamed at her to get some kind of approval and praise. Approval was not forthcoming. She said, "Mr. Nations, that is a fourth grade song!")

We're beginning to get a little bit smarter. We're beginning to say, "Let's look at learning problems and let's look at content." We're beginning to say, "There are some major concepts that run through areas of knowledge and there are some major kinds of understanding that run all the way through the content area." We are beginning to organize learning problems on this kind of continuum based around major concepts, major processes, major understandings, major skill areas of development. Then, we are getting smart enough to say, "This youngster can deal with this concept in this way, and another one deals with it in another way and at a different point along the line." So much for learning problems and some new dimensions in learning problems.

What about new dimensions in expectations? This is a time when we probably have more focus on early childhood education than we have ever had before in our educational system. The regional educational laboratory where I work focuses all of its activities on early childhood education. Of the twenty regional laboratories in the country, I understand twelve have early childhood education, either as a major focus or as a secondary focus. I think this is a good illustration of the importance that we are placing on early childhood education.

But this didn't just happen; it came about for a number of reasons. First of all, the curriculum development reform movement started in the secondary schools. What happened was that the people at the universities were saying, "What do we want freshmen in college to be able to do?" Then they said, "If freshmen have to do this kind of thing, then what should seniors in high school do and what should juniors and sophomores do?" until they finally got down to the fourth grade and somebody said, "Just a minute. We are imposing all of these things down to the fourth grade, and the poor kids can't handle them."

There are numerous national projects in curriculum development. Most of them start at the top and build down. They get to the fourth grade, and all of a sudden, they are in trouble. So now we are beginning to say, "Let's look at the learners and see what they are capable of doing, what kids are capable of learning from the time they are two or three all the way through the educational process." So we're beginning to look at expectations. We're beginning to find, first of all, that young children are capable of a great deal more than we had expected. There are certain kinds of things young children can do that we never knew they could do. If we build from this basis and go through the schools, we find tremendous capabilities and achievements in our youngsters.

I don't know how many of you have had a conversation recently with a very, very bright high school student -- it's frightening! Even the knowledge of young children is frightening. I have a five-year-old who was talking the other day about the skeletal system of sea animals and the differences between the skeletal system of sea animals and vertebrates. All of a sudden, I thought, "I didn't learn that until I was a freshman in college."

I am constantly finding that young children are talking about what I found exciting when I was in college. And some of the subjects teenagers, some of these highly achieving youngsters, are discussing are equally amazing. On the other hand, there is so much emphasis in this country on providing good educational opportunities for all students that we have to look at the wide range of achievement abilities.

We are at a time in our country's history where, unless we view human potential as our major resource, the country will go down the drain. This is a country that has said, "Every citizen has a right to make his voice heard; every citizen has a right to make the best contribution that he can to society." Therefore, school systems are responsible for looking for the capabilities of every student.

We are beginning to recognize that as we talk about expectations and capabilities of students, we have to understand that capacity within one learner does not indicate equal capacity across the board. Some students can achieve exceptionally well in one area and not as well in other areas. This means that we need to look at students realistically if we are going to define expectations for them. Frequently I go into schools where they have the fast children, the average children, and the slow children. Do you know what happens when you do a study of differences within the children? Things get so mixed up that you can't tell which one is supposed to be slow and which one is supposed to be fast.

One of the most exciting things in education now is that we are talking about a variety of kinds of intelligence. There is the intelligence that knows how to deal with academia. There is the intelligence that knows how to deal with the street. There is the intelligence that knows how to deal with the community. And there is the intelligence that knows how to deal with creative problems. We need to look very carefully at the kinds of intelligence that various youngsters have. I think too often in education, we have looked only at the kind of intelligence that can deal with academia. Then we discount the others; we are wasting potential and we are wasting talent. So what I am saying is that there is a new dimension of expectations, that we are looking at a broader range of expectations.

All right, let's move to the element of situations or learning environment. We are a fairly materialistic society, so we focus a lot of our energies and a lot of our finances on material things. And we're beginning to come up with some exciting materials. I don't know how many of you might have seen the television shows a couple of years ago on things that were happening in the schools. Each network produced a television show, in which the uses of computers in instruction were discussed. The problem is that we don't know what to use them for once we have them. We spend all of our time developing these machines, but then we don't know exactly how to use them. We have psychologists who say, "You tell me what you want the youngsters to learn, and I can see to it that he learns that thing because we have all of the means."

Our problem is how to use those means. What kind of ends are we going to foster in the schools? We have a lot of new dimensions in learning situations and learning environments, but they aren't going to do us much good until they are plugged in with all of the other elements and looked at in terms of those elements.

The newest dimension in evaluation is that we are beginning to look at the learner as being one of the most significant agents in the evaluation process. Frequently I see situations where people are talking about difficulties in finding out something about youngsters. There is a simple question that can be asked, and that is, "Did you ask the kid, did you ask him?" Most often, the teacher will say, "No, I hadn't thought about that," or, "He wouldn't know." Make no mistake: youngsters know. They evaluate their situations, they evaluate themselves, and they are the most important agents in evaluation.

Now let me talk about new dimensions that center around the learner. First of all, we are beginning to organize learners in a different way. We're organizing youngsters into nongraded classrooms because we realize that one individual contains within himself a variety of levels of potential. We realize that the growth is not a sequentially even process, but one that goes by leaps and spurts -- so we need the flexibility to allow a youngster to achieve at his peak in every area within the curriculum. We have begun to organize youngsters on a nongraded basis.

We are finding out that there are many kinds of learning and there are kinds of learning that take place in a variety of situations. One kind of situation might be good for one kind of learning, and another kind of situation might be good for another kind of learning. Traditionally, we have put thirty children with one teacher, and they stay together six hours a day throughout the school year. Now, we are beginning to say, first of all, "If we are talking about information-type learning, in which the teacher gives some knowledge or gives some data to the learner, the students might as well be put into large groups. Why should teachers be coming from all over the school to give them the same kind of information?" So we put youngsters into large groups if it's an intake situation. If there is an output situation, we find that it is necessary sometimes to have youngsters in small groups or to put them in individual learning situations. We are beginning to reorganize learners into large-group, small-group, and individual-learning situations. More and more of the time in schools is being spent on individual learning practice with youngsters, and this is as it should be.

But when we start doing this type of reorganization, we have to reorganize the teachers also. So we come up with teaching teams where a number of teachers will be responsible for a group of youngsters. Then, when we reorganize the teachers, we say, "Let's look at what the teacher is doing and what kind of resources can be brought in to the teachers." We are beginning to say, "The teaching team should include support services, diagnostic services, social, and growth services." All of these kinds of things need to be fed into teachers.

I think there are two kinds of organization that are most appropriate and most profitable. These are the nongraded organization of learners and the organization of learners into teaching-learning teams. (As a matter of fact, I think I would rather use the term "learning team" than teaching team.) Essentially, then, what is happening with learners is a reorganization, and, as I have said before, we are reassessing the kinds of expectations we have for learners.

I hope that what I have conveyed to you is that we are looking at schools; we are looking at every element of schools. There is nothing that is sacred about school situations because we are trying to question every element. It is only with this kind of questioning, and this kind of analysis, that we can really begin to develop the new curriculum, and that we can really foster new dimensions in curriculum. It is only through this kind of development that we can bring the very best to bear in instructional settings with the learner. And our focus is the learner!

New Trends in the Health Curriculum

Miriam L. Tuck

Actually, there really are no new trends in health education curricula. As far as I know, the cognitive areas were always supposed to have been based upon the health problems of youngsters. However, to many persons this meant teaching anatomy and physiology first and then attacking the problems -- and by that time, the teacher had lost the youngster's attention. Today in education, it is fashionable to say, "Be innovative." Wasn't the good teacher always the one who skillfully interwove facts with everyday problems?

Today, however, a greater portion of the public and the young are subjected to health knowledge based on a deliberate attempt to activate fear. If all of the dire threats we heard on T. V., and even in some responsible health literature (i. e., the trapdoors in our stomachs getting stuck; ordinary everyday problems causing us to have anemia, constipation, tired blood, diarrhea, dyspepsia, what-have-you), were true, only a very few of us would have been able to hobble to this conference! Therefore, students and the public in general just "tune out." They say, "I'm feeling well. Leave me alone!" They really have to be stimulated to listen.

Health educators (and everyone in the health business is health educating in some way), in order to combat this apathy, must be able to combat the trapdoors in the stomach, the tired blood, the nostrums for anything and everything; they must be able to speak out truthfully with the facts; they must be able (and willing) to help the public separate the important facts from the unimportant. In addition, health educators must be able to gather together all concerned for concerted community health education efforts, and they must try to set an example. (Those of you who must smoke in school -- your actions speak so loud the students cannot hear what you are saying!!)

Obviously, then, the goals of health education are related to those of all education, both where basic subject matter is concerned and in their ultimate aim, helping the youngster reach his minimum potential. Effective health education does more than this, since good health frees the individual to live up to that potential.

Despite the constant bombardment of the communications media, the great majority of the public is not health-educated. The recent School Health Education Study revealed frequent misconceptions on all grade levels, such as the following:

- Commercial medicines are safe to purchase if the label clearly indicates the dose and contents, or if recommended by a pharmacist.
- The use of "pep" pills and sleeping pills does not require medical supervision.
- The purpose of fluoridating water supplies is to purify water and make it safe to drink.
- Chronic diseases can be transmitted from person to person.
- Venereal disease can be inherited.
- The World Health Organization is part of the International Red Cross.
- Physical fitness and endurance naturally increase as adolescents grow up.
- For specific health problems, the sources of help chosen as best by high school seniors were as follows: 1) for a persistent skin inflammation, a nonmedical health adviser or a pharmacist; 2) for a persistent cough, a pharmacist; and 3) for a painful back injury, a chiropractor. [1]

And there were more. In last year's CBS National Health Test, only 29 percent of an "educated" public had a practical knowledge of health. Did you know that 95 percent of the drugs in use today were unknown five years ago?

What are some of the health problems which affect all of us?

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[1] Sliepcevich, Elena M. School Health Education Study: A Summary Report. Washington, D. C.: SHES, 1964.

- The nation's population was 140 million in 1945; it is 200 million now; it is expected to be 250 million by 1980 and 400 million by 2010, only about 40 years from now.

- Approximately 90 percent of our urban population lives in localities which are affected by air-pollution hazards -- radiation fall-out, smoke, smog, fumes, and chemicals. Recent studies have related these hazards to bronchitis and have suggested relationships with pleurisy, pneumonia, and circulatory failure.

- Health scientists have added tremendously to man's knowledge about health problems and their solutions, providing unprecedented opportunities to prevent ill health and save lives. However, the Public Health Service estimates that failure to use preventive and early case-finding techniques is responsible each year for 88,000 deaths from cancer; 20,000 deaths from rheumatic heart disease; and for needless suffering of millions of persons from other ailments.

- The United States now ranks 15th in the world in terms of neonatal deaths.

- Accidents cause more deaths than any other single illness (except cancer and cardiovascular disease) and are highest in the 1 to 25 age group. Basic to the reduction of accidents is an understanding that they are not the products of Fate, but rather the results of a definite sequence of events and, like disease, are subject to epidemiologic study.

- Mental illness affects 17 million people, fills every other hospital bed, and costs over $3 billion annually.

- Among our middle-aged and older people, there are special hazards of premature death or disability from chronic diseases. Each year 900,000 people die from heart and blood vessel diseases; 260,000 die from cancer. Millions are affected by these and other diseases, such as arthritis, diabetes, alcoholism, and glaucoma.

- To complicate these problems, there is a serious shortage of physicians, nurses, dentists, and other public health and paramedical workers -- yet a great percentage of college youngsters cannot decide which career to enter. A stimulating health education course might help bridge the gap.

Recent trends in health curricula emphasize health science as a multidisciplinary area; therefore, there have been changes in the preparation of health educators. In some instances, the health program is now encompassed in a school of public health; in others, in a school of education. Health, as defined by the World Health Organization (WHO), is the "state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity." Since there are so many factors which have a bearing on health, the trend is to combine the health major with sociology, anthropology, psychology, counseling, and other related areas.

Because of this new emphasis, several curricula innovations have emerged -- e.g., team teaching, modular scheduling, conceptualization, systems approach, closed-circuit television, programmed learning, teaching machines, etc. -- which again apply to all subject areas. I would like to explore some of these briefly with you. In one conceptual approach resulting from the School Health Education Study, the hierarchy stems from health, its most comprehensive concept; thus, all of the content is derived from health and its meaning. The three key concepts -- growing and developing, decision-making, and interacting -- are the unifying threads of the curriculum plan and "characterize the process in the life cycle that is typical of every individual." The three dimensions of health -- physical, mental, and social -- interact and interplay with the life processes represented by the key concepts.[2]

The third level of the hierarchy consists of ten concepts, which serve as the "organizing elements of the curriculum" and make up the scope of health education. This scope functionally provides the answer to the question of what to teach at all levels. Some of these concepts are:

- Growing and developing follow a predictable sequence, yet are unique for each individual.
- Protection and promotion of health are individual, community, and international responsibilities.
- The potential for hazards and accidents exists, whatever the environment.
- There are reciprocal relationships involving man, disease, and environment.
- Utilization of health information, products, and services is guided by values and perceptions.

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[2] School Health Education Study. Health Education: A Conceptual Approach to Curriculum Design. St. Paul: Minnesota Mining and Manufacturing Co., 1967.

There are at least a half dozen other approaches to conceptualization throughout the country, including the school health division of AAHPER. Many school systems do not require health education. In these systems the school nurse is the key person in interpreting the school's needs, both to the administration and staff and to the community. Health service logs can be quite helpful in demonstrating student health education needs (e.g., types of visits, frequency, reasons for absence-frequency, excuses from participation in physical education, kinds of accidents, cafeteria use, etc.). The health service program is an integral part of the triad of health (in combination with health education and a healthy environment).

Another area where the nurse can be the initiator is in interpreting the need for inservice courses in health education. A great proportion of the teacher-training institutions do not require even one course in health appraisal or instruction; some require only one. How can there be adequate teamwork for helping the child to reach his best potential if some team members have no idea what their concerns should be?

Others on the program will be exploring the nurse's role more deeply; therefore, I will not belabor the subject. However, with the tremendous emphasis on health needs today, there has never been a more propitious time to start new health programs or to strengthen old ones. I hope all of you will use this conference as a springboard for revitalizing the total health program in your part of the country.

I would like to conclude with an engraving from a very old tombstone in a cemetery across from my office in Oregon:

Remember, friends, as you pass by,
As you are now, so once was I
As I am now, you soon shall be.
Prepare for death and follow me.

(Below in pencil, is written:)

To follow you, I'm not content
Until I know which way you went.

There may be a message here for some of us, since the only difference between a grave and a rut is the depth!

The Nurse's Role in Health Education, Part I

Mabel B. Kepler

In New York State, our title is School Nurse-Teacher. Sometimes we must explain this title, but I am glad the "teacher" part is there. We are teachers and we have a vital role in education. Using our preparation in nursing and education, we can be catalysts. We can make something happen in education.

Recent developments in health education are encouraging. New methods of teaching, i. e., the conceptual approach, have been devised. Audiovisual materials are more plentiful and of improved quality. Curriculum guides are being developed at the national, state, and local levels. The duplication of efforts seems wasteful; however, we can use what is available and adapt it to our needs.

The nurse-teacher should be a member of the health curriculum committee as a consultant and resource person. Implementing the health education program is the joint responsibility of administration and faculty. If parents and others in the community serve on an advisory council, the nurse-teacher can interpret the entire school health program to them. Community understanding and support are especially necessary in these times of budget trimming.

Education for nursing gives us a foundation of scientific information, making the nurse in the school the health expert. This background is valuable, but understanding the educational process is equally important. As part of the educational system, we must know what education is about: what current developments in educational psychology are, how children learn, what motivates them to change behavior and attitudes, what teaching methods work best at a particular grade level, and what the best techniques for teaching the slow learner are. We must be familiar with a variety of educational media, know how to evaluate them, and know how to improvise when funds are low.

New legislation in New York State mandates health education in all grades, K-12. At the secondary level, health is to be taught by certified health teachers, but these will be in short supply for some time to come. The classroom teacher will be responsible for elementary health education.

Until teacher education institutions improve the preparation of classroom teachers, inservice education will be needed to bridge the gap. Good interpersonal relations and understanding of group dynamics will enable the nurse-teacher to work effectively in this area. Many teachers tell us that they need more time for teaching basic subject material. We must convince them that health education is equally important, and help them to do it.

It is helpful to determine what is already being taught in health and related areas, such as science, hygiene, homemaking, etc. A checklist will give some indication of topics being covered, but will not measure depth of coverage. Analyzing the findings of a survey will help classroom teachers realize how much is already being done and where improvements are needed. The nurse-teacher might give some demonstration lessons, offer suggestions of community agencies who have materials, or offer the names of speakers.

Working in this setting also gives the nurse-teacher an opportunity to interpret the effects of health problems on a pupil's ability to learn.

What I have said so far indicates that the nurse-teacher must be some kind of superhuman dynamo. There is no doubt that she will be different in many ways from some nurses in schools. Her function will be more than the 9 to 3 dispenser of band-aids, record keeper, and screening technician. She must set priorities for using her time and be willing to delegate responsibility to auxiliary personnel.

Keeping up with developments in health and education may seem an impossible task. The opportunities are there in the form of conferences, workshops, inservice and graduate education, and lectures. Reading journals in each field is very helpful. Certainly active membership in professional organizations is a must; it is part of being a truly professional person.

In the February 1968 issue of the Journal of School Health, Dr. Delbert Oberteuffer says of health education, "If our values are straight and we value human life above all else, then health education becomes one of the master areas in all of American education. Along with language. It deals, or should deal, with the nature of life and problems of life management, with all those phenomena that are indigenous to being human, which develop or retard, create or kill. Nothing is more important. Time must be found for it."

Part II

Edith H. Vincent

I concur with Mrs. Kepler that the school nurse should serve as a resource person and consultant in the health education aspect of the total health program in the school, even in writing health curricula. We should add, however, that she needs to be qualified to do this, and after listening to several of the speakers during this workshop, I am not sure what this really encompasses. How can the school nurse serve as either a resource person or consultant -- say, for instance, in sex education -- if she hasn't kept up-to-date on materials, information, and practices. The school nurse needs more than to be familiar with recent developments in an area. She has to be able to get this material across. Too often we have geared our projects to giving and receiving information without really involving the students. I don't know how we are going to do it, but until we place a high priority on the "personal" involvement, little success will be realized in our programs. I may sound old-fashioned, but I feel we have to find a way to convey the feeling to our students that we really do care about them and are concerned about them as individuals.

There are several ways to try to reach our audience with our ideas. One way is rather informal -- through the use of bulletin boards, displays, posters, and slides. You have seen several illustrations of these on display today. At this time, I would like to give recognition to an old friend, Betty Manchak, who has taken my ideas and made them look professional. I have little art ability, but as a team we have prepared materials and exhibits such as you see before you. I am sure that you will be able to find someone in your area who is willing to work with you. It really makes the task easier and more rewarding to function as a team.

Other ways that you may be asked to present information are more formal -- such as speaking in the classroom; working with PTA groups and community groups; contributing to inservice programs for teachers; and participating in special programs on drugs, venereal disease, alcohol, etc. Here again, the important thing to remember is how to "come across" to your audience -- sincerity, genuine concern, and adequate knowledge are just three of the ingredients.

In many of the projects undertaken in the school, I view the school nurse more as a coordinator and a member of a health team than as a resource person. In a pilot project on sex education in which I was engaged this spring, the success of the program was due not to my efforts as coordinator but to how well the members on the health committee functioned as a team. Each member had a responsibility; the librarian, for instance, compiled a bibliography of all the materials, including books, pamphlets, filmstrips, and transparencies, available to the faculty and students in the school's library. Copies are available to you today on the bibliography table. So much more can be accomplished in working with people than alone.

I feel, too, that the school nurse should be alert to creativity -- to develop new materials, new approaches. The transparencies which the art teacher and I did on venereal diseases two years ago grew out of requests from students and teachers to develop some visual materials on this subject. Students, teachers, and parents were involved in the development of these transparencies, which are being commercially reproduced at the present.

It is an exciting experience to be a school nurse if your horizons are unlimited. It thrills me to see school nurses across the country associated with health projects on smoking, sex education, drugs, etc. I think the nurse has a key role to play in helping to initiate programs of this nature. This spring, at the request of my administrator, I was asked to "do something" about the smoking problem in our school. The traditional approaches seemed to be grossly inadequate. In working with two small discussion groups of "problem" students who were smokers, I learned a great deal about the problems by listening to these students and involving them in evaluating current materials. They asked to go to an elementary school to talk with the 4th, 5th, and 6th graders, and they did a terrific job. Lately I have become interested in the emotionally disturbed child. Did you know that one of the indications of the emotionally disturbed child is the frequency and intensity of illness complaints with which he comes to the health room? How many school nurses use the health records to counsel students and to alert teachers to possible conflict in the classroom? This, too, is health education. Too often we are near and with students but not "tuned in" to their pleas for help.

The school nurse today should be cognizant of the opportunities that lie in the projects funded by the federal government and the trainee programs, such as may exist in the Education Professions Development Act. Recently I had the privilege to serve as a consultant in reading proposals concerned with health, especially sex education. In many of these proposals, school nurses were included.

Health education does not stop in the schools; the school nurse herself needs to speak out for school nursing instead of leaving the responsibility to other groups. She needs to educate, by whatever techniques are feasible, the school personnel and community as to the unique role of the school nurse as it relates to the total school program. Too often it is easier to follow than to be a leader. I challenge you to become the latter.

New Dimensions in Nursing and Nursing Education

Eleanor C. Lambertsen

I want to talk with you today about some newer dimensions in nursing and nursing education. Possibly you have already discussed some of these, but I feel at this point that it may be important for us in nursing and health education to emphasize and re-emphasize and possibly say in different ways some of these things that have new meaning for us today in the whole health field. Current issues in nursing education and nursing practice are reflections of the nature and magnitude of social change. Rapidly occurring changes in science, technology, social structure, intellectual concepts, and economic and political establishments have brought signs and symptoms of social stress, all clearly evident in the dissatisfaction of consumers of health services as well as in the changing attitudes of health personnel about the scope and purpose of their work.

A recent report of the National Commission on Community Health Services describes the scope and purpose of essential comprehensive personal health services of high quality for all people in each community. The report indicated these services should be directed toward the promotion of positive health, application of preventive measures, early disease detection, effective treatment, and physical, social, and vocational rehabilitation.

Shortage of Manpower

The health services available to the citizens of this nation are being adversely affected in both quantity and quality by the shortage of physicians, nurses, health educators, social workers, occupational therapists, and numerous other members of essential and emerging health disciplines. The forces underlying the growth and demand for health services are powerful and continue to generate constant pressure to expand regardless of the availability of personnel and financial or physical resources. The conflict inherent in the expression of goals for health services and the resources to achieve these goals is self-evident, for the major problem we face today in our nation is a shortage of talented manpower.

Public concern with regard to scarcity of health personnel focuses primarily on the medical and nursing profession. The shortage of physicians and nurses is intensified by the scarcity of talented manpower in all other professional and supportive occupations in the health service field. Certainly those of you in the school are aware of this and of the expanding role of the nurse in the school health system where there are no supportive members of the health team present. Attempts to provide increased services to the citizens result in further dilution of the quality of these services where the approach has been to employ more and more personnel with less and less preparation for major responsibility.

It is hypothesized that an objective analytical appraisal of nurse-individual-family interaction will identify the common elements in nursing for a group of people. The variants we must consider are the nature of the potential or actual health problem, and note the word "potential." Age, sex, culture, and intellectual and personal resources of the individual and his family are common elements that we are concerned with in our multiple role in the cycle of health. Second are the individual's physiological needs in response to a health problem. Third are the individual's psychosocial needs in response to an actual or potential health problem or problems. Nursing is primarily related to the whole area of health maintenance or restoration of normal body function or life processes.

Change in Place and Therapy

When I hear people ask what the role of school nurses is, I am more than ever concerned with the significant role of nurses in the social institutions, such as the school, and the potential adaptive response of individuals. The ultimate goal of any program of nursing care is to maintain or achieve the maximum degree of health attainable for or by an individual. Increasingly, the administrators of health services in institutions and the physicians are criticizing the skill and competence of graduates of schools of nursing, criticizing the newly employed graduate who does not know how to carry out certain nursing techniques, etc. The decreasing amount of time a student spends in a clinical environment has been viewed as the cause of limited skill in nursing. But in all instances employers and critics of graduates of our current system fail to recognize that it is the difference that exists in hospitals or health agencies of various size and type that really influences the practice of nursing. In a large medical center, for example, it may be customary for interns to carry out certain techniques which are the responsibility of a nurse in a nonteaching community hospital. Also, there is increasing evidence that techniques previously administered on the wards by nurses are now carried out in special treatment or service areas by the technicians.

When some of our young graduates start on their programs, they have to be reoriented to some of the techniques that need to be carried out in the home. Also, the hospital recovery room or intensive care units provide certain services and techniques that were formerly done in the hospital ward. The student of nursing, therefore, has limited opportunity to experience some of the procedures that I remember doing quite frequently. How aware are we when we criticize the young graduate who comes into our particular occupational group of some of these changes that have affected her experience?

There is also limited opportunity in the care of certain types of cases within the hospital. The pediatric experience has been lowered considerably in hospitals with an increasing emphasis in a collegiate program in the care of the child in an ambulatory setting. The emphasis in this shift may promote a greater interest in school nursing and public health nursing. In the obstetrical service in the teaching hospital, there is a limited opportunity for students of nursing to have an experience with mothers because of the shortened stay. The whole area of helping the family to adjust to the introduction of a new child comes not in the hospital any longer but in the home.

Nursing Personnel versus Nonnursing Health Personnel

In our country, particularly in the smaller school setting, the smaller the social institution in which we provide health service, the less apt it is to have supportive specialists. Specialists who are few in number, such as the social worker, occupational therapist, and social psychologist, often gravitate to the larger urban centers and larger medical centers, so we find fewer and fewer of these specialists available in the rural United States.

Problems associated with the shortage of talented manpower in nursing have resulted in increased attempts at more effective utilization of available nurse power. This is the problem you will face, and I would like to share with you an example that demonstrates the basis for decision-making. (Sometimes in our haste to differentiate between nonnursing and nursing we may have a tendency to delegate a significant phase of care to someone who is less well prepared to handle it than the professional practitioner.) I selected a pediatric example because I think the principles I am using here have pertinence to you in your work with children in the school. The Methodist Hospital in Brooklyn has been actively engaged in an appraisal of the factors within the hospital which affect the quality and scope of nursing practice and the quality of nursing care. One recommendation for change in hospital routine was that the dietary department serve and distribute meals to patients instead of having the nurses perform this duty. The decision that this service would be provided by the dietary department was not innovative, as it is increasingly prevalent in hospitals; what was unusual was the decision that nursing service would retain the total responsibility for meal services on the pediatric ward. Why was this distinction made? Numerous reports and research involving children have revealed the effect of hospitalization on children during a period of stress. Separation from a normal life situation for the child is likely to produce tension, anxiety, and fear. This could also apply to the situation where the child is entering school and leaving what was his normal life style. How can the nurse reduce the element of strangeness and reduce the number of caretakers? An awareness of the basic problems influenced the decision of the nursing staff of the Methodist Hospital. The conclusion that meal service for children was a nursing service responsibility was based on the results of research and study demonstrating the effect of fragmented personnel relationship as compared to sustained relationship in caring for children.

In planning how to use supportive personnel in nursing, we must realize that there are certain kinds of duties that may not seem to come under the heading of nursing, but they really do because of their therapeutic value for the child at a particular time. If it is important to sustain relationships in caring for children to eliminate the number of caretakers, how do we determine priority?

Another recognizable phenomenon affecting the practice of nursing is that of increased specialization. There are two ends of the spectrum where we see specialization clearly being described. If delegation of activities to other supportive personnel in a cluster of related activities essential to professional service can be isolated and controlled, it tends to create another occupational group. If people start out to be assistants to a professional, if the job is large enough and there is a body of knowledge that can be identified, the workers then become another occupational group which claims a specialty of its own. The cycle is repetitive, for as workers in this occupation begin to enlarge their functions, they soon require assistance; thus we find narrowing and narrowing specialization on several levels. Many of these specializations have recently been formulated: occupational therapy, recreational therapy, and physical therapy, to name a few -- all vital areas that have emerged from the disciplines of medicine and nursing. Within a relatively short period of time these occupations have been deemed essential to total health services and, as a result, have become highly specialized.

The same phenomenon of increased specialization at two extremes of the occupational continuum is increasingly evident in nursing, for physicians as well as nurses are now advocating that the preparation of the professional nurse practitioner for a clinical specialization (now predominantly at the master's level) should take place at the post-master's level.

I hypothesize that the interdependence of medicine and nursing is such that the areas of similarity of function will be greater. Psychiatric nursing, for example, has been developed to the extent that it is possible to delineate this area of specialized clinical nursing practice. Direct nursing care functions include individual psychotherapy, group psychotherapy, family therapy, and social service. These are functions of the nurse, but they are also functions of other workers within the team, such as the psychiatrist, the clinical psychologist, and the social worker. It is the nature of individual problems, family problems, and group problems that determines whether the therapy will be carried out by a nurse, a social worker, or a clinical psychologist. In psychiatry there has been little debate about the expanding role of the nurse.

But symptoms of indignation were clearly evidenced by nurses when a new program was initiated by the Colorado School of Medicine to train public health nurses on the post-master's level for increased responsibility in the care of children in low income families and to administer most of the normal pediatric care originally handled by physicians. Public health nurses and school nurses have had a long heritage of providing normal care, and I fail to see what the issue was. Case finding, promotion of health, and prevention of illness have long been a role of the public health nurse and the school nurse. It can be predicted by physicians as well as nurses that the nurse will be expected to assume more responsibility for ambulatory patients and those in nursing homes and other facilities outside the hospital. The emphasis on health care services unfortunately has been primarily upon effective treatment achieved by medical science and technology. Less dramatic progress has been realized in some of the other health service areas identified in the definition of comprehensive health care. Many persons are hospitalized for conditions that could have been prevented or minimized by following sound personal health practices or by carrying out medical instructions.

It was stated at the National Conference on Medical Costs in June 1967 that the greatest potential for improving the health of the American people was not to be found in increasing the number of physicians or in forcing physicians into groups or even in increasing hospital facilities but was to be found in what people do and do not do for themselves. The school is one of the nation's biggest social institutions that must face this challenge. With so much attention given to medical care and so little to health education and individual responsibility for the promotion of health, we run the danger of supporting the understandable urge to buy a quick solution to a difficult problem. There is a shortage of educational specialists and health educators essential for public participation in health programs on a well-informed and intelligent basis. Priority must be placed on coordination of the various health education programs and on health communication.

Every health worker who is in close contact with the people has a potential influence on the knowledge, attitude, and health practices of the people with whom he works. In order that the best results accrue from these contacts, it is essential that doctors, nurses, midwives, environmental sanitation workers, and others with a special health knowledge become more conscious of their educational responsibilities and approach them with confidence, optimism, and a variety of techniques. The definition of a program of health services and the availability of these services are a constant source of public debate. We are now at a point that is crucial; we may go back to the distant dark ages in medicine, nursing, and education if we continue to support without question the idea that people less and less prepared can assume more and more responsibility. This is quite different from asking how can we add supportive personnel to the health team to function directly under leadership, supervision, and direction of the professional.

It is not just a question of numbers; it is the talent that proves the need to carry out these services faithfully, efficiently, and therapeutically. A spectrum of patient care means that the services will be available through a number of different types of agencies in addition to the hospital. These include home care programs, community health programs, school health services, industrial health services, and the personal services of the physician and other health professionals. Continuity of services and coordination of these services are essential and means must be achieved which will ensure that the health professionals assume the responsibility for defining their services on a community basis rather than continue to define the service on the basis of the employing institution.

Leadership in a Period of Change

Charles H. Goodman

As you know, my area of discussion with you is "leadership in a period of change." Permit me first to sketch a few ideas and concepts about this subject so that we may have some common positions of understanding. Essentially, I am going to speak about three things:

1) What is leadership?

2) What style of leadership is needed to meet the changes of our times?

3) How can one improve his leadership ability?

Following this, I will try to transfer these thoughts into the area of your work to see if they might be helpful.

Let us start with a simple question, which, like so many other simple questions, turns out to be a most difficult one: What is a leader?

The answer to this question has changed as it has been studied, and I am sure it will continue to change as we learn more about leadership.

At the turn of this century there was widespread belief that leaders were born; one did not or could not develop or train a person to be a leader. Consequently, it was the belief that leadership was essentially based upon personality.

Then an attempt was made to try to understand leadership in terms of the kind of person who makes a good leader. This question produced long lists of traits which attempted to differentiate leaders from followers. One would hear or read such adjectives as dynamic, dominant, aggressive, forceful, confident, and so on. But this type of research or speculation produced little in the way of understanding leadership, and gradually this trait concept of leadership disappeared, for there was little agreement on what these traits were.

During the latter part of the 1940's, a number of studies were conducted on the kinds and styles of leadership; the results of these studies began to draw attention to such kinds of leaders as the autocratic leader, the democratic leader, and the laissez-faire leader. The importance of this research was that it began to focus attention on the effects of leadership behavior on those being led by the leaders. Most of the recent research on this leadership problem has been directed toward trying to answer the question of what an effective leader does or what the functions of leadership are. As a result of this type of research, it has been found that the functions of leadership do not always have to be carried out by the leader and that many of the things that need to be done can be carried out by the members of the group involved.

These findings have led to the belief that group decision-making can be more effective and more motivational for a group and that a leader who encourages group participation is looked upon as a person who helps the group to be more creative and productive. It is from these concepts that the ideas of democratic leadership and permissive leadership (as opposed to autocratic leadership) have evolved.

Let me see if I can now summarize and make more tangible some of these points: There is considerable research evidence that 1) leaders are not necessarily born; 2) one cannot gain much from a traitist approach to leadership or the personality concept of leadership; and 3) understanding the functions of leadership can be more rewarding and fruitful than those concepts which were previously espoused.

Can we then establish a definition for leadership in terms of present-day thinking? I would offer the following: Leadership can be defined as the process of influencing the activities of others to behave in a desired manner for the purpose of achieving a goal or goals.

This definition involves the situation or situations in which one is functioning; the leader and subordinates; the necessary influence to get people to do the things needed; the manner, the way, or the avenues to achieve the goals or objectives the group wants; and a differentiation between the function of the leader (what he does) and that of the individual or group (what they do).

I would like to comment on an issue that must be considered at this point. It is the issue we refer to as the leadership vs. the headship problem.

By "headship," in your case, we mean that you have been named chief nurse of surgery by the hospital director or chief nurse in charge of all high schools by the superintendent of schools. In this situation, you have been placed in charge by the organization. It is hoped that you have been given the necessary authority and responsibility. You are the "head person," the person in charge. You can give orders to people; you can promote people; you can discipline people. Does this mean you are a "leader?" In an authoritarian sense, yes -- you give the orders. But does this mean the people who work for you consider you a leader in the sense of wanting to be directed by you, wanting to carry out the things that need to be done to accomplish goals which both you and they feel are needed? Being a supervisor -- being in a headship position -- does not necessarily make you a leader.

What, then, is the significance of this new approach to leadership in terms of the present? I believe we would all agree that present-day conditions are most volatile. This is a period of rapid change. It is a period of radical change. And the urgent question that confronts us is: "What kind of leaders do we need to meet these changes?"

From all that we have witnessed so far, it would appear that the authoritarian leader is least likely to be able to deal with the problems of a democratic society.

Our whole trend in the U. S. has been and continues to be that of giving greater initiative and greater freedoms to people. We want people to think; to question; to get involved in the problems, politics, schools, and community; and to participate in helping to make the decisions that will affect them. People in our communities today want to be involved in the policies of their schools, their hospitals, their roads, their city governments. Students in universities are demanding the right to select the college president, the faculty, and the curriculum. Teachers want to have a voice in school curriculum, methods of teaching, and salaries.

All of these fundamental changes in our society have raised new expectations, new attitudes among Americans. Our educational levels have soared. So has the demand for more responsibility, more authority, and the right to participate in decision-making. Can the authoritarian leader hope to survive or function as a leader in this climate?

Let us return, then, to your particular situation, that of the school nurse. What should your leadership role be? (Of course, if you don't want to cause waves or stir up problems, then you will disregard all of the following that I speak about). I think your role has two major aspects to it. The first of these is program content. The second is that of your leadership in promoting your programs, gaining support, instituting change, and evaluating your programs to determine their value and accomplishments.

The following questions must then be posed and answered by you: What is my program now? What are its deficiencies? Its strengths? What needs to be done? What are the needs of the students? The school administration? The faculty? The community?

Now, you could easily evade these questions by saying that there are no needs, that everyone is very happy. I would then ask: Do you have a perfect program? Is it that you can't be bothered? Doesn't anyone expect or want anything different? Is there ever something that is so perfect that it can't be improved? Or that new needs can be ignored?

Now, if you find that things need to be changed or that new programs need to be introduced, your skills as a leader must be put to work. Some or all of the following questions may face you: How can I get the needed support? What opposition will arise? How can I overcome this resistance? How can I introduce these changes with the greatest degree of acceptance? How can I communicate this need or these needs to others so that they will want to work to accomplish these goals? Would it be more effective for someone else to take over the leadership to accomplish certain objectives? How might the local medical association be of help? The nursing association? The P. T. A.? The county medical director? Your state legislator? The bar association?

A major part of your success will depend upon your ability to be an effective leader. Can you improve your leadership abilities? We believe you can if you are willing to make the effort.

How can you go about improving these abilities? First, make an assessment of yourself as realistically as you can. Put it down on paper. Ask yourself the key question, "What kind of a leader am I now?" Then ask, "What kind of a leader do I want to become?" Other specific questions that you should ask yourself include: How flexible am I? How good is my sensitivity in sizing up a situation or a group problem? How well do I communicate with others? Do I get my ideas across clearly? Do I irritate people in a discussion? Can I sense the needs or problems of a group? Can I crystallize these needs for the group? Am I tolerant of different views? Can I get the members of a group to open up and give their views? What is the level of my ability or skill in defining problems? What do I know about leadership and its practice?

Basic to these questions is the foundation of these elements. Be aware, for instance, of what you need to know to be a better leader. (You can acquire this knowledge by reading lectures and by discussing these matters with other leaders.)

Your own attitudes or feelings will also be highly important. Do you really want to be a good leader? Try out new approaches -- by such means as permissive discussions and varied techniques of counseling. How good are your insights and understanding of problems? Analyze your own experiences; experiment; get reactions from individuals or groups. (You will need to develop these skills by practicing them in groups, workshops, etc.)

There is a story of a young man who went to Aristotle and said, "I want to learn to become a great harpist -- what shall I do?" Aristotle is said to have answered, "Play the harp."

Becoming a good leader calls for the same practice. I can only conclude by saying that if you want to be effective in your work, you must become an effective, modern leader.

Summary and Challenge to the Conferees

Elizabeth C. Stobo

I suppose that it is natural that a talk, or a summary as this is intended to be, might include some reference from current readings. As you know, John W. Gardner's most recent book, No Easy Victories, was published last week. The following paragraph from that book seems applicable here:

> "Professions are subject to the same deadening forces that afflict all other human institutions: an attachment to time honored ways, reverence for established procedures, a preoccupation with one's own vested interests, and an excessively narrow definition of what is relevant and important."[1]

For the past three days we have been challenged to think of ways in which we might free ourselves from these very fetters. School nursing today was quickly identified as being different from that in the past. Today's practices are far removed from inspections for nits and lice and those communicable diseases for which there are now adequate control measures. Without neglecting or dwelling on the concerns of the past, the conference papers have dealt with the present but always with an eye on the future. The need to assess scientifically that which is being done or planned was encouraged by the use of study or research methods, more specifically by the epidemiological approach.

Studies recently completed, or now underway, were presented to offer directions for greater analysis and further changes in ways of working. Several times it was pointed out that priorities needed to be set. This led to questions as to the basis for establishing priorities. A further provocative question was: To what extent do we use the information we now have?

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[1] Gardner, John W. No Easy Victories. New York: Harper and Row, 1968, p. 42.

The background for all of the discussions was obviously the late 1960's, more specifically 1968, with all of the concerns reflected in current legislation, curriculum innovations, and social, economic, and cultural problems which affect the lives of the children we serve.

As we progressed with our program, it became evident that practices by nurses in schools today will be influenced by changes in the broad field of nursing and nursing education. These changes, along with those in the fields of education and health, must reflect a sensitivity to the demands of our society. Such sensitivity is essential if vitality is to be maintained.

It is the maintenance of this vitality that is the challenge to the conferees. There can be no standing still while the present steady stream of change which marks our life today moves on. For every new innovation in medicine, an adaptation in nursing seems necessary. Innovations in the field of education are influential, too.

The term comprehensive health care was mentioned several times. What form this will take in the distant future is hard to ascertain. It may be anticipated that the organization for health services will be different. The American dream is always for more readily available, good quality services. The services must be available for more people in the general sense and also in terms of close proximity to where they live. The technology of the future will reduce distances in space as it has in the past. The types and kinds of personnel necessary will vary, also. It is conceivable that in the not-so-distant future, those children who come to school at a younger age will come with the usual, and some new, immunizations completed. They will also have had all of the current screenings for vision and hearing acuity, speech proficiency, and other screenings before they arrive. Facilities for medical and dental follow-up will be available, and referrals for physical and emotional problems as we now know them will eliminate the need for some of the present kinds of school health facilities because they will be community-based. This is a challenge and not a threat (as it well might be if we were unprepared and unwilling to discard the fetters I spoke of earlier). In this changed school and community health environment of the future, the school nurse will still be working with children, their families, teachers, and a myriad of other school personnel. The new scheme of things will permit her to locate those young people who need her the most, the high risk group, and she will be able to spend more time with them as needed. She will not lose the common touch! Many children will need her services in quite a different way, and she will also have a key liaison function between home, school, and the comprehensive health facility.

The new knowledges from education about the learning processes will be used in every child contact and in adult contacts, too. Our increased knowledge about individual differences -- made more explicit by our understanding of the learning process and our greater knowledge of genetic, social, cultural, and nutritional influences -- can make our approach to teaching (individual and group) more applicable for the individual as a learner.

We have to run now to keep abreast of new information. To be in a position to use new knowledge as it accrues in the years ahead will require changes not only in the lower grades, but also in high schools, colleges, and graduate schools. New extension and inservice work will become available. New scientific information will be collected, collated, and synthesized so that it may be dispersed more readily and in a more usable form for the rapidly increasing number of consumers wishing to have their knowledge updated. Some sort of screening may have to take place, and there will be arguments as to what information should be screened out and what should be left in, but those arguments are for the future. We shall face them when we have to decide on which packages of information we shall select (much in the manner in which we now select packages of food or TV dinners). At future conferences we may, among other things, discuss, from the point of experience in local communities, the merits of the content of Scientific Package 1, 2, 3, etc. Are you ready for this? I am! I think that it will be great! Right now I am ready and stimulated to go back and look at priorities as to what we shall keep and what we should discard. I am challenged to look at the various study findings which tell us that some of the "sacred" things we have been doing for years are not going to pay dividends in terms of either finding or dealing with health problems. I shall look forward to further findings from the Delaware study reported on by Dolores Basco, in order to locate implications for school nursing practice. I shall check the Stobo, Shoobs, et al., study for priorities to be found there, and look into the Bryan study to see how school nurses can realign their valuable professional time in order to use it where it can do most good.

I hope that you are feeling a similar challenge. You have the further responsibility to go back and share this challenge with others in your own areas. This is your leadership responsibility; this is why you came. Some of you who have heard me speak before have heard me use a quotation from the late Paul Mort's book on school administration. I regret that I did not bring it with me, but the gist of it is this:

> The school should always be a school on the hill. Out of the valley come children to that school on the hill. At the end of each school day children carry lights from the school back to the valley. The lights carried by the children daily, from the school on the hill to their homes in the valley, soon become a stream of lights glistening throughout the world. Part of our challenge is making this stream of lights brighter than ever before.[2]

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[2] Mort, Paul R. Principles of School Administration. New York: McGraw-Hill, 1946, p. 13.

Conference Implementation and Evaluation

During each day of the conference, a period was set aside for the conferees to meet in geographical groups to discuss the implications and implementation of the formal presentations.

Inasmuch as AAHPER is already divided into six district associations, it is anticipated that these structures may serve the conferees as a basis for developing future conferences of similar nature. It is conceivable that one or more states may cooperate and coordinate future planning. Each October issue of the Journal of Health, Physical Education, Recreation carries a roster of national, district, and state officers of HPER structures, who will be helpful in local implementation.

Before the leadership conference adjourned, the conferees completed an immediate evaluation form. It is anticipated that follow-up evaluations will be repeated at a later date, and surveys will be made to determine the extent of implementation on the local level. It is hoped that a follow-up report of this conference will later be prepared.

The staff and officers of the American Association for Health, Physical Education, and Recreation stand ready to help in any way possible. Additional rosters of local resources are available upon request from the Consultant for School Nurses, AAHPER, 1201 16th Street, N. W., Washington, D. C. 20036. It is hoped that in addition to seeking assistance, individuals will report their accomplishments to this office.

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